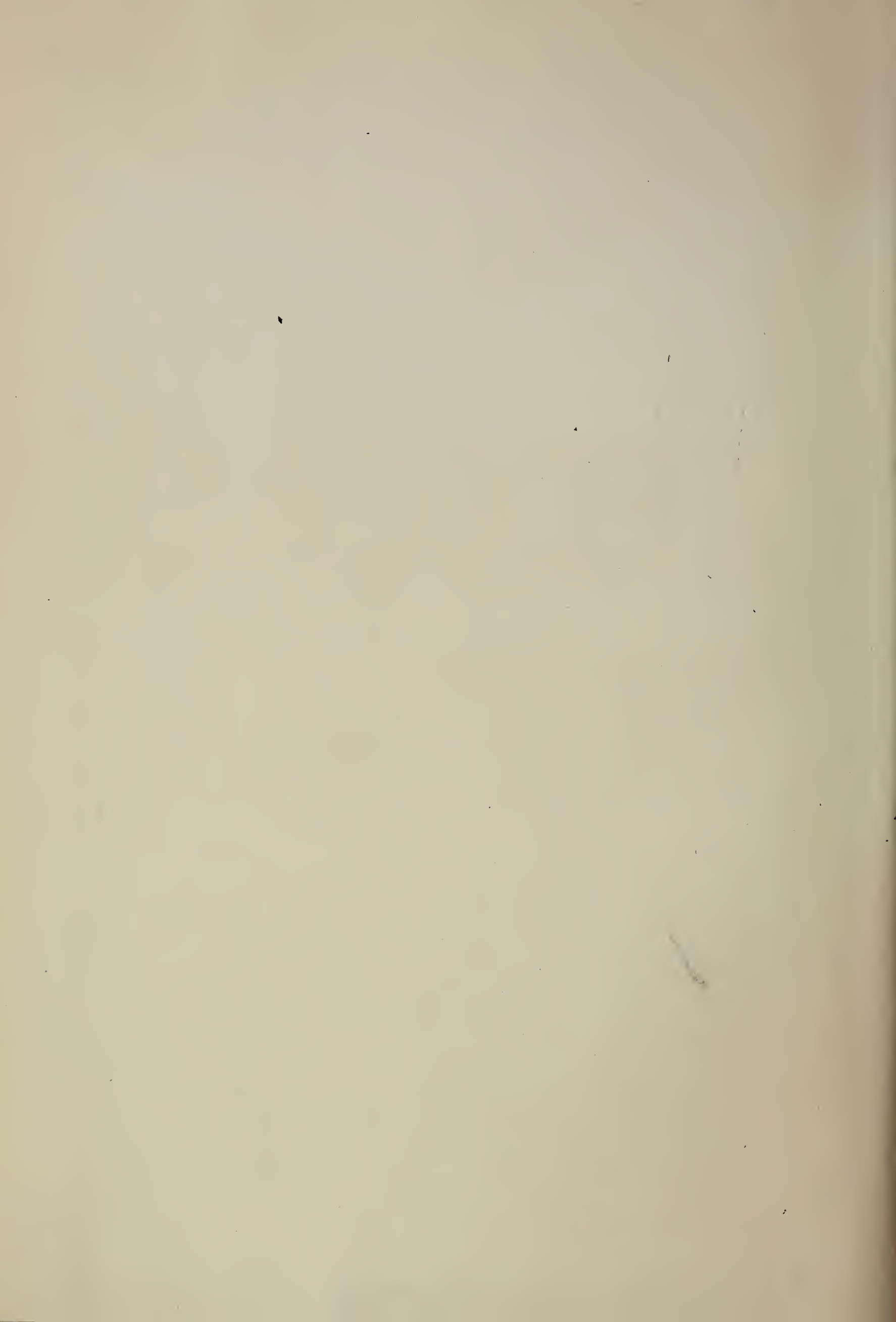






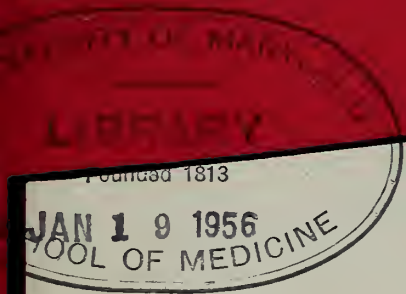
January 1956

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VOLUME 52

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NUMBER 1

*The Ohio State*

MEDICAL JOURNAL

The Council:

Important Matters Acted upon
At December 10-11 Meetings Page 52

1956 Annual Meeting:

Main Features of Program,
April 10-12 in Cleveland Page 65

AMA Clinical Session:

Summary of Actions Taken at
Boston Meeting Page 70

H. R. 7225:

Warnings on Proposed Revamp
Of Social Security Laws Page 80

Turn to Inside Front Cover for Complete Index

The Ohio State Medical Journal

Vol. 52

January, 1956

No. 1

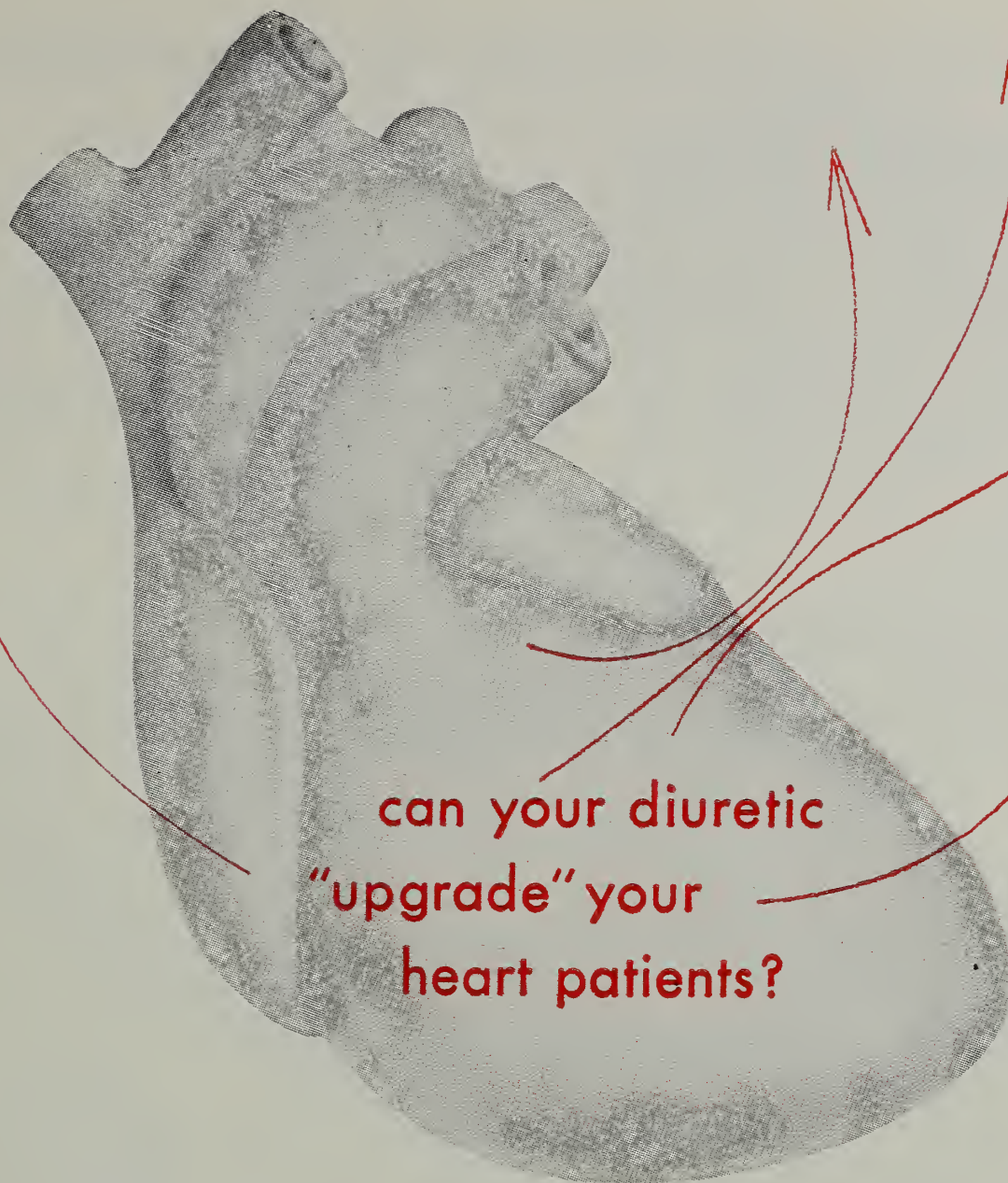
Published monthly by The Ohio State Medical Association, 79 East State Street, Columbus 15, Ohio. Subscription, \$5.00 per year to non-members; Single Copy, 50 cents.

Entered as second class matter July 5, 1905, at the Postoffice at Columbus, Ohio, under the Act of Congress of March 3, 1879; Acceptance for mailing at special rate of postage provided for in Section 1103, Act of Oct. 3, 1917. Authority July 10, 1918.

The Journal does not assume responsibility for opinions expressed by the essayists. Advertisers must conform to policies and regulation established by The Council of the Ohio State Medical Association.

Summary of Contents

The Achievement of Ambulation in Psychiatric Patients. Janice A. Mendelson, M. D., Dayton	25
Environment and Mental Illness: A Study of Urban-Rural Differences in Social Organization. Robert M. Frumkin and Miriam Z. Frumkin, Buffalo, N. Y.	32
The Treatment of Gonorrhea with Oxytetracycline Intramuscular. Ollie M. Goodloe, M. D., M. P. H., and Louis J. Roth, M. D., Columbus	34
Low Back Pain. Ben R. Wiltberger, M. D., Columbus	35
Management of Conjunctivitis. William H. Havener, M. D., Columbus	40
Franklin County Pelvic Cancer Delay Committee Report. John H. Holzaepfel, M. D., Columbus	42
Diseases of the Nervous System. (A Pediatric Review.) Edward C. Matthews, M. D., Cincinnati	43
Clinicopathological Conference	45
The Historian's Notebook: "The Dromedary Symptom Complex": The Evolution of an Error. Byron Stinson, M. D., Clarksburg, Ohio	50
Historic Hildreth Home in Marietta to Remain for the Present	51
Physician's Bookshelf	10
Proceedings of The Council	52
Two Drugs in Short Supply	57
Dr. Schriver Honored for His Work with Blue Shield	57
Maternal Health Committee Report to The Council	60
Ohio Dentists Hold 90th Session	60
Public Relations and Economics Committee Report to The Council	61
Annual Conference of County Medical Society Officers	63
Private Medical Schools Included in Grants of Ford Foundation	63
Congress on Industrial Health To Be Held in Detroit	63
1956 Annual Meeting	65
Hotel Reservation Page, 1956 Annual Meeting	66
Application for Space in Annual Meeting Exhibit	67
Do You Know?	68
Still Will Have Polio Problems, NFIP States	68
Ohio Medical Indemnity Celebrates Coverage of Two Millionth Member	69
A. M. A. Clinical Session	70
New Members of Association	74
New Certificates of Birth and Death	76
Iowa Court Rules That Hospitals Which Profit From Services of Physicians Are Guilty of Corporate Practice	78
H. R. 7225—Its Dangers	80
In Our Opinion:	
Age Groups Should Be Observed in Giving Polio Shots	84
BIE Day—Has Your Society a Part in It?	84
Mansfield Physicians Use the P. R. Approach	84
Better Get A Film Catalog	84
Charging Colleagues a Fee for Services	84
Policy on Immunizations and Examinations	85
What About Medication of Athletes?	85
When in Doubt, Better Check	85
In Memoriam	88
Licensed Through Endorsement by State Medical Board	90
Activities of County Societies	92
Activities of Woman's Auxiliary	98
Dr. Forman Attends Watershed Meetings in Washington	106
Another Low in Mortality Rate	106
Index To Advertisers	106
Classified Advertisements	107



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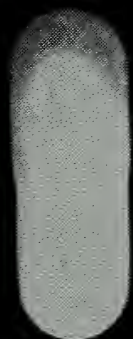
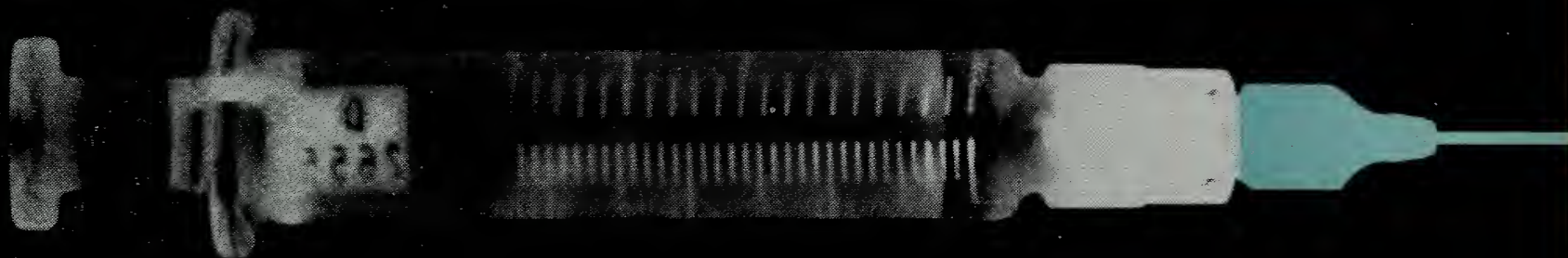
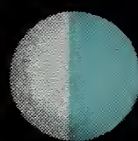
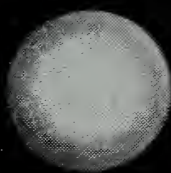
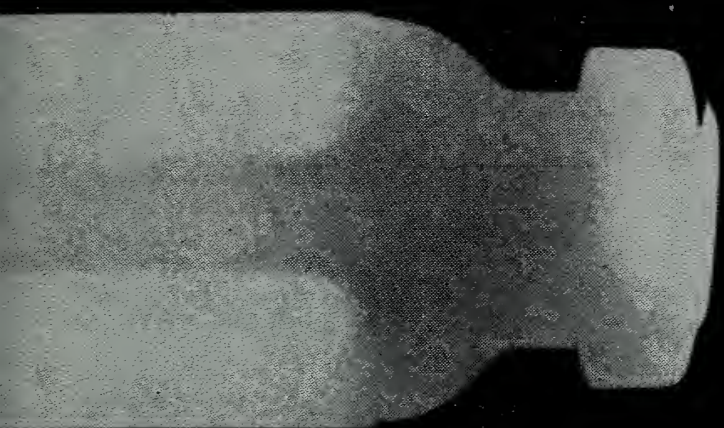
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Textbook of Operative Surgery, by Eric L. Farquharson, M. D., (\$15.00. *E. & S. Livingston, Ltd., Edinburgh*. Distributed in the United States by *Williams & Wilkins Co., Baltimore 2, Maryland*). This is a one-volume work written by a general surgeon and designed to present, as far as possible, the whole subject of operative surgery in a balanced perspective from the standpoint of general training. There is much to be said for works of this kind to use as a teaching tool in comparison to texts on operative surgery which are products of multiple authorship.

Incest Behavior, by Dr. S. Kirson Weinberg; Introduction by Dr. Herbert Blumer, (\$5.00. *The Citadel Press, New York 10, N. Y.*). This book represents a definitive study of the Universal Offense of interfamily sexual relationships based upon firsthand, documented evidence. This is the first book-length analysis of this type of behavior. In analyzing the several aspects of the incest taboo and incest, it relates incest behavior to personality development, to the social structure of the family, and to society as a whole. It is documented throughout with material obtained from interviews with incest participants and families in which incest has occurred.

Group Therapy for Mothers of Disturbed Children, by Helen E. Durkin, Ph. D., (\$3.50. *Charles C. Thomas, Springfield, Ill.*). Out of an extensive clinical practice in psychotherapy, wide reading, and an effective integration of the two experiences, the author has written a most useful book. It relates group psychotherapy to clinical diagnoses in terms of therapeutic practice. She believes that this extension of analytic group psychotherapy validates the claim that this branch of psychiatry has emerged from its experimental phase.

The Two Faces of Man, by Joost A. M. Meerloo, M. D., (\$4.00. *International University Press, Inc., New York 11, N. Y.*). Man's basic ambivalence forms the center of this study. It attempts a synthetic view based upon a biological-psychological and clinical-psychiatric frame of reference.

The Story of the Growth of Nursing, as an Art, a Vocation and a Profession, by Agnes E. Pavey (\$5.00. Fourth Edition. *J. B. Lippincott Company, Philadelphia 5, Pa.*). To anyone interested in the care of the sick, reactions of past ages to sickness and suffering make fascinating reading. Here we have, recorded briefly, the heroism and devotion of those ancient kings, queens, and commoners alike, whose efforts have become historical. In this way the author tells the story of the birth and development of

each phase of nursing from its earliest beginnings to its present form. Each branch of nursing is described in the country of its origin and forms an excellent background for consideration of present standards of nursing education. Without some knowledge of the origin and development of all sciences upon which nursing rests, it is difficult to understand how one can have a sound knowledge of the subject.

Fundamentals of Psychoanalytic Technique, by Trygve Braatoy, M. D., (\$6.50. *John Wiley & Sons, Inc., 440 Fourth Avenue, New York 16, New York*). This is fresh appraisal of methods of psychotherapy by the late head of the Psychiatric Department of Ulleval General Hospital, Oslo, Norway. The book is oriented toward the patient, toward observation and careful description, and toward psychosomatic medicine in an attempt to gain insight into the problems of psychoanalysis.

Hyperostosis Cranii, by Sherwood Moore, M. D., (\$10.50. *Charles C. Thomas, Publisher, Springfield, Ill.*). This is clinical and anatomical study based on 522 hyperostotics, 1267 controls, and 1478 skeletons. It covers the Stewart-Morel Syndrome, Metabolic Craniopathy, Morgagni's Syndrome, Stewart - Morel - Moore Syndrome (Ritvo). The statistics in this book are critically analyzed.

How to Keep Romance in Your Marriage, by S. Clark Ellzey (\$2.95. *Association Press, New York 7, N. Y.*). The author insists that romance can be kept alive and may become more powerful and more meaningful through the years of marriage than it was before the wedding. It has been written in the hope that it will be of help to the minister, marriage counselor, professional therapist, and friends of the newly married.

Your Health Today, by William W. Bauer, M. D. (\$5.00. *Harper and Brothers, Publishers, New York 16, N. Y.*). This was written by the Director of the Bureau of Health Education of the American Medical Association, as a popular text in the Harper Series in School and Public Health Education, Physical Education, and Recreation and edited by Delbert Oberteuffer of Ohio State University.

The Adult-Child Interaction Test: A Projective Test for Use in Research, by Theron Alexander, (\$4.50. *Child Development Publications, University of Illinois, Champaign, Ill.*). This is a projective test consisting of eight cards showing pictures of children and adults about which subjects are asked to tell stories. There is a

method of analysis in the form of an outline containing two main divisions: Apperception and Reasoning, and Motivation and Emotion. There is also a shortened method which is in the form of a chart.

Cold Injury—Transactions of The Third Conference, February 22, 23, 24 and 25, 1954, edited by M. Irene Ferrer, M. D., (\$4.50. *Josiah Macy, Jr. Foundation, New York, N. Y.*). Twenty-two physicians participated in this particular Conference to discuss Circulatory and Metabolic Factors, Metabolic Studies of the Eskimo, A Comparative Study among Young Males, Fat Distribution and Respiration, Diet and Survival, and Ascorbic Acid and Subcutaneous Fat.

Adrenal Cortex—Transactions of the Fifth Conference, November 4, 5, and 6, 1953, edited by Elaine P. Ralli, M. D., (\$3.75. *Josiah Macy, Jr. Foundation, New York, N. Y.*). This Conference, held at Princeton, New Jersey, devoted itself to three topics: Salt and Water Factor of the Adrenal Cortex, the Metabolism of Adrenal Steroids, and ACTH—a Single Substance or a Mixture of Hormones.

Gestation: Transactions of The First Conference, March 9, 10 and 11, 1954, edited by Louis B. Flexner, M. D., (\$5.00. *Josiah Macy Jr. Foundation, New York, N. Y.*). Nineteen physicians met to discuss the Functional Role of the Placenta, Sugar Transport in the Ungulate Placenta, the Anatomy of the Placental Barrier, and Enzymes of the Human Placenta.

Connective Tissues—Transactions of The Fifth Conference, February 8, 9 and 10, 1954, edited by Charles Ragan, M. D., (\$4.25. *Josiah Macy, Jr. Foundation, New York, N. Y.*). The multiprofessional conferences sponsored by the Josiah Macy, Jr. Foundation are an attempt to stimulate research and to promote effective communication across departmental walls which tend to isolate professions. In this Conference three topics were discussed: The Exchange of Materials Between Blood Vessels and Lymph; Interstitial Water and Connective Tissues; and Hormonal Effects on Connective Tissues.

Studies in Medicine, presented to Aleksander Rudolf Klossner on his 60th birthday (Supplement to *The Annales Chirurgiae et Gynaecologiae Fenniae*, 17 Yrjönkatu, Helsinki, Finland). This volume is dedicated to the first holder of the Chair of Surgery of the University of Turku. He is one of the outstanding men of medical science and an inspiring teacher of surgery. Some 540 pages of interesting articles from all fields of surgery are brought together to do this teacher homage.

Cardiovascular-Renal Problems—Clinical Pathologic Conferences of Cook County Hospital, Volume I, edited by Hans Popper, M. D., and Daniel S. Kushner, M. D., (\$5.00. *The Blakiston*

Company, New York 22, N. Y.). An excellent collection of CPC's from this famous institution on this important subject.

Growing into Maturity, by Kathryn Brudorlin Crisp, (\$0.40. *J. B. Lippincott Co., Philadelphia 5, Pennsylvania*). A small teaching manual used in the Public Schools of Denver, Colorado.

Biochemistry and Physiology of Nutrition, Vol. I, edited by G. H. Bourne, and G. W. Kidder, (\$13.00. *Academic Press, Inc., New York 10, New York*), gathers into one work the most salient segments of the vast amount of research dealing with the field of nutrition.

The Human Adrenal Cortex. Ciba Foundation Colloquia on Endocrinology, edited by G. E. W. Wolstenholme and Margaret P. Cameron. Vol. VIII. (\$10.00. *Little, Brown & Company, Boston 6, Massachusetts*). Particularly important are the chapters on the reaction of the adrenal cortex in conditions of stress, metabolism of adrenocortical steroids in humans, discussions on the biosynthesis, clinical and metabolic effects of aldosterone, Cushing's syndrome, and many others.

Human Physiology, by Bernardo A. Houssay, M. D., and Staff, (\$12.00. 2nd Edition. *McGraw-Hill Book Co., Inc., New York 18, N. Y.*) translated by Juan T. Lewis, M. D., and Olive T. Lewis. An internationally acclaimed text from the pens of Dr. Houssay, a Nobel Prize Winner, and his associates. The book is unique in that the authors of the specialized section have led an ideal intellectual life with almost daily contact. Herbert M. Evans, of The University of California, says in his introduction, "All North American Colleagues of these Argentine scientists now welcome warmly this signal accomplishment of the group."

Industrial Dust, by Philip Drinker, S. B., and Theodore Hatch, B. S., (\$10.00. 2nd Edition. *McGraw-Hill Book Company, New York 18, N. Y.*). This is a comprehensive approach to engineering, laboratory and medical aspects of dust control in relation to workmen. Special features of this edition include: treatment of particle dynamics, the newer engineering methods contributing to silicosis control and other particles, modern concepts of inhalation, and the role of respirators.

Should the Patient Know the Truth?, A Response of Physicians, Nurses, Clergymen and Lawyers, (\$3.00. *Springer Publishing Co., Inc., New York 10, N. Y.*). Here the patient is the center of the composite response. It's the patient's well-being that counts. The task is to recognize, respect and accept the patient's feelings, however different they be from one's own. Specific guidance is given as to timing and for specific situations.

Etiology of Chronic Alcoholism, by Oskar Diethelm, M. D., (\$6.75. *Charles C. Thomas, Pub-*

lisher, Springfield, Ill.). Written by the Professor of Psychiatry at Cornell University Medical College, and five associates for the investigator from medical, biological, psychological and social fields. It represents the results of a five year program of investigations by a team from various disciplines.

Pulmonary Diseases, edited by Roscoe L. Pullen, M. D., (\$15.00. *Lea & Febiger, Philadelphia 6, Pennsylvania*). Some 21 well known chest men—allergists, bronchoscopists, laryngologists, physiologists, and tuberculosis experts—have combined to produce a comprehensive presentation of all types of chest disease.

Forceps Deliveries, by Edward H. Dennen, M. D., (\$6.50. *F. A. Davis Company, Philadelphia 3, Pa.*). This is another in a series of monographs on obstetrics and gynecology, edited by Claude E. Heaton, M. D., of Bellevue Hospital. This is a book for the resident staff of every maternity ward. It describes the various forceps, giving their indications, and describes and illustrates how to use them.

Regional Enteritis, by Frederick F. Boyce, M. D., (\$2.35. *J. B. Lippincott Co., Philadelphia 5, Pa.*). This book gives the diagnostic criteria and the therapeutic considerations. The author attempts to interpret his experience with this condition in the light of the general recorded facts and opinions.

Medical Nursing, by Edgar Hull, M. D., and Cecilia Perrodin, R. N., (\$5.00. *F. A. Davis Company, Philadelphia 3, Pa.*). This is the fifth edition of this well known text. The authors maintain their former success in integrating the facts of practice with those of nursing so that the student gets a thorough understanding of general medicine and how patients on its service are to be cared for. All of the modern techniques of education are employed in arranging the text.

Surgical Nursing, by Eldridge L. Eliason, M. D., L. K. Ferguson, M. D., and Lillian A. Sholtis, R. N., (\$4.75. *J. B. Lippincott Company, Philadelphia 5, Pa.*). This is the second printing of the tenth edition of this standard text. "To cut well, sew well and nurse well means to get well." This makes the patient as a human being anxious to have the operation and get well its primary purpose.

Angiographic Localization of Intracranial Masses, by Arthur Ecker, M. D., and Paul A. Riemenschneider, M. D., (\$13.50. *Charles C. Thomas, Publisher, Springfield, Ill.*). It consists primarily of a series of cerebral angiograms in proved cases of intracranial masses. The illustrations show the displacements of arteries and veins caused by space-taking lesions in some 27 specific locations.

The Care of Your Skin, by Herbert Lawrence, M. D., (\$2.50. *Little, Brown & Company, Boston 6, Mass.*). A popular treatise on how to treat acne and how to overcome it. Most of us who have not suffered with this affliction in our adolescence cannot appreciate how seriously acne does affect the development of a personality as well as the appearance of young men and women. This book is a good one to place in your patient's hands.

Current Concepts in Digitalis Therapy: A Guide to The Use of Digitalis Drugs, by Bernard Lown, M. D., and Samuel A. Levine, M. D., (\$3.50. *Little, Brown & Company, Boston 6, Mass.*). The physician treating the cardiac patient sooner or later has to employ one of the group of digitalis drugs to improve the function of a failing myocardium. In this little book, we find both the experimental and clinical evidence of the profound relationship between the state of the body electrolytes and the action of digitalis. The present-day practice of sodium restriction makes this relationship of vital concern. The book further provides a method for determining digitalis requirements when these are in doubt.

Stress Situations, by Samuel Liebman, M. D., (\$3.00. *J. B. Lippincott Co., Philadelphia 5, Pa.*). This small work consists of seven important essays by distinguished psychiatrists: (1) Emotional Reactions to Frustration and Failure, by Lewis L. Robbins; (2) Emotional Reactions to Acute Illness, by Francis J. Gerty; (3) Emotional Reactions to Catastrophe, by John P. Spiegel; (4) Emotional Reactions to Marriage, by Leo H. Bartemeier; (5) Emotional Reactions to Sterility, and Fertility, by Boris B. Rubenstein; (6) Emotional Reactions to Divorce, by Harry H. Garner; (7) Emotional Reactions to Death and Suicide, by Jules H. Masserman.

Doctor Monkey and His Jungle Friends, by Carter Anderson, (\$2.00. *The Vantage Press, Inc., New York 1, N. Y.*). The remarkable doings of this busy medico and his animal patients. They all talk and act like your patients. Captivates young readers and makes excellent bedtime stories. Better, however, you will find these stories of great help with the little patient who may have to wait in your office.

Biological Specificity and Growth—Symposium edited by Elmer G. Butler, (\$5.00. *Princeton University Press, Princeton, New Jersey*). The Society for the Study of Growth and Development annually brings together a group of active investigators from various fields to discuss important problems of growth. This volume is a report of the 12th in this series. The physiology of development, the phenomenon of specificity occupies a prominent place. It is with an examination of the reactions within cells and among cells leading to specific types of growth and differentiation that this symposium deals.

The Ohio State Medical Journal

Published under the direction of The Council for and by the members of The Ohio State Medical Association, a scientific society, non-profit corporation, with a definite membership, for scientific and educational purposes.

Vol. 52

January, 1956

No. 1

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The Achievement of Ambulation in Psychiatric Patients

JANICE A. MENDELSON, M. D.

THE maintenance of optimum circulatory and metabolic status in surgical patients is known to be dependent on adequate mobilization of the patient pre- and postoperatively. In many institutions concerned with the care of the mentally ill, a rather large proportion of "bedridden" patients is seen.

Among typical reasons given for these patients remaining in bed are the following:

1. The patient just does not want to get up.
2. Patient had a hip fracture and by the time healing was complete, his muscles seemed too weak to permit ambulation.
3. Appears to have too extensive contractures to be able to stand.
4. Too old and feeble.
5. Unsteady on feet.
6. Had a stroke.
7. Not enough personnel to help.

This presents a particular problem when these patients require emergency or elective surgery, and it was initially for this reason that a plan for the achievement of ambulation in such patients was devised at the Dayton State Hospital. It was then applied to all nonambulatory psychiatric patients.

To obtain successful rehabilitation it is essential to orient the ward personnel in the aims and methods, emphasizing the increased efficiency of ward management as well as the improvement in the patient so obtained. The methods should be simple enough to be carried out by properly

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instructed attendants with supervision by the medical and nursing staff, as they are designed for institutions having a minimum of ward personnel, usually without physical therapists.

PURPOSE

There are many reasons for encouraging ambulation of as many patients as possible. These may be summarized as follows:

1. Improved Mental Status

An otherwise mentally normal person is apt to become apathetic, anorexic, and dependent when confined to bed for a long period of time. The regaining of the ability to walk about, thus changing the environment even slightly, to eat meals seated at a table (preferably with other people), and to go to the bathroom, produces a definite increase in mental alertness, improved interest in self-care, and often a visible euphoria.

This type of improvement can be seen in elderly patients who are not mentally ill, as well as those with cerebral arteriosclerosis and senility. The benefit is marked in many schizophrenics of any age, particularly the catatonic, as well as in depressed patients.

In the mentally ill, the attaining of ambulation in a previously nonambulatory patient may be

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Submitted October 25, 1954.

partly due to an improvement in the psychiatric status, but more often the reverse is seen. Thus, when a catatonic patient who appears completely immobile is helped out of bed and ambulation attained by the methods described below, some improvement in the psychiatric status may occur before any other treatment is given. When the patient is able to walk, it becomes easier for him to reach more varied occupational and recreational activities, further aiding his mental status.

2. Improved Physical Condition

The most important reason for encouraging ambulation is physical. Prolonged bed rest has been proven to produce marked metabolic changes even in mentally and physically normal individuals. A classic study in this respect was done by Deitrick, Whedon and Shorr,¹ who observed the effects of immobilization on healthy men who were placed in plaster casts for 6 to 7 weeks.

Nitrogen, phosphorus, total sulfur, sodium and potassium all showed increased excretion during this period. The urinary calcium content was doubled although the volume of urine did not change. There was significant decrease in muscle mass and muscle strength in the immobilized limbs. There was deterioration in the mechanisms essential for adequate circulation in the erect posture as indicated by an increased tendency to faint in tilt table tests. There was a decline in the total blood volume and marked decreases in exercise tolerance. The recovery or return to control levels of most of the physiological functions tested required 3 to 4 weeks, six weeks or more being required for some of the effects to disappear.

It is well known that prolonged bed rest predisposes to phlebothrombosis with possibility of pulmonary embolism, venous stasis being encouraged by lack of active muscular contraction of the legs. The tendency to hypercalcemia and hypercalcinuria, particularly in the presence of a high urinary pH, is conducive to the formation of urinary tract calculi. The associated osteoporosis predisposes to the development of fractures after relatively mild trauma, such as merely falling out of bed. When lying in bed patients do not breathe deeply, and particularly the elderly individuals are apt to develop atelectasis and "hypostatic pneumonia."

3. Greater Ease of Nursing Care

A patient who can walk even a short distance can be out of bed while the linens are changed, can walk to the bathroom, and can eat at a central location, e. g., dayroom on ward. The time spent by ward personnel in carrying bedpans and trays, and in making beds, is thus minimized.

The improved condition of the ambulatory patient's skin and general nutrition helps prevent the development of complications requiring special therapy.

Physical activity as in walking often helps relieve emotional tension which might otherwise be expressed in less acceptable ways.

METHODS

(A.) EVALUATION

1. Physical Examination

When a patient has been in bed for several months, his physical status is first investigated to determine whether he can be encouraged to stand immediately or whether preliminary strengthening exercises are to be given. Probably the only real contraindication to the weight bearing position is the presence of certain unhealed fractures or active osseous disease such as tuberculosis or neoplasm, or of complications such as recent phlebothrombosis. The method of weight bearing ranges from "standing" on a tilt table, as in quadriplegia, to unsupported full ambulation.

Severe flexion contractures prohibit normal weight bearing and must be improved before this can be accomplished. In many of the mentally ill it is exceedingly difficult to differentiate organic contracture from voluntary flexion on a psychiatric basis. The simplest method of differentiating these is by distracting the patient during the examination. For instance, a tightly flexed knee may be seen to extend easily when the patient's attention is diverted by conversation or by examination of the upper extremity.

Similarly, when it is difficult to ascertain whether the patient is voluntarily resisting attempts at passive extension of a flexed joint, if instead, one passively further *flexes* the joint, if resisting the motion the patient will use his maximum extension power. If the passive flexion is then suddenly released, extension may occur. This is particularly effective in hysteria, malingering, and involutional melancholia with somatic manifestations. Deep tendon reflexes may be utilized to produce motion in a joint which at first appears "frozen." Similar techniques are used in determining whether paralysis is present.

2. Special Laboratory Studies

Electrical stimulation when available is a good way of verifying the presence of paralysis and has value in the treatment of certain temporary paralyses.² However, its use is greatly limited in the mental institution where some patients are overly frightened by the procedure and will be less cooperative thereafter.

Electromyography can also be utilized where necessary as a valuable adjunct in differentiating certain organic neuromuscular lesions from functional disabilities.^{3, 4, 5} Using data such as those given by Schwartz,⁶ the electroencephalograph available in many institutions can be adapted for rather gross electromyography where more specialized instruments are unavailable. This technique actually is rarely needed in evaluating most

of the nonambulatory psychiatric patients whom we have seen.

3. Other Aids in Evaluation

Extremities which are held in the flexed position either for psychiatric reasons or because of mild pain, or as the result of contracture, can be actively and passively stretched with greater ease in a warm tub bath. This has a sedative effect, helping the patient to relax, helps relieve pain, and supports a limb in which the muscles may be weak from disuse or paralysis. Although the Hubbard tank is preferable, the hydrotherapy tubs or even ordinary bathtubs have been used effectively. (Although other forms of heat therapy are known to be effective, the bath is the only one described throughout this basic plan. We feel it is the simplest, safest, most readily available and most generally beneficial device to be used by relatively unskilled personnel.)

When none of these methods enable the examiner to differentiate a functional from an organic contracture, the use of examination under anesthesia is justified, but we have found it rarely necessary.

(B.) PROCEDURES

1. Treatment of Contractures

It is to be emphasized that the fact that the mental patient has apparently held his trunk and extremities in a position of flexion for several years does not necessarily mean that organic contracture is present. We have been amazed to see a patient who had apparently remained entirely flexed (fetal position) for three years, straighten out completely except for a very mild contracture of the right knee, and become able to walk without assistance using the methods to be described below. We do not yet know the explanation for this.

Patients with flexion contractures of the knees and hips are encouraged to lie on the abdomen as much as possible. Gravity then becomes a valuable ally in producing stretching. If the knees are held tightly flexed they are gradually extended by placing "ABD pads" in the angle so formed, avoiding pressure on the popliteal space. The bulk of the pads is gradually increased each day until small pillows, then padded posterior splints can be applied where necessary to maintain the gain accomplished after exercise. The gentle passive (and active, if possible) stretching, preferably in or following a warm tub bath, is done at least once daily.

In our experience, surgical release of contractures is not often required in the psychiatric patient. It would be particularly indicated in the presence of a severe lower extremity contracture (knee especially) not improved by physiotherapy and persisting under anesthesia in a patient responding well to psychiatric treatment.

2. Preambulation Exercise Program

(a) *Bed activities*

In the "bedridden" patient, ambulation is at-

tained in progressive stages which are outlined as follows.

1. All patients should sit upright in bed for meals. Practically the only contraindications would be recent spine fracture, unconsciousness or shock. This increases their interest in their environment, increases the sense of well-being, prevents aspiration of food and fluids due to difficult swallowing in the recumbent position, improves the pulmonary status (increases vital capacity, helps patient breathe more deeply), and usually permits them to feed themselves more effectively. A patient who is encouraged to feed himself is less apt to develop an infantile, dependent attitude and more apt to want to walk and do other things for himself.

2. After the patient sits up well with a backrest, he should then sit on the side of the bed with feet dangling. At first he is carefully observed for syncope and to prevent his getting out of bed completely if not yet ready for weight bearing. This position strengthens the back muscles, and, if the patient is encouraged to swing his legs while sitting in this position, helps mobilize the knees and ankles. Whenever possible, a patient who must remain in bed should eat in this position from the onset of bedrest.

3. There are simple exercises that all patients confined to bed can do to prepare them for the resumption of ambulation.

Whenever possible, changes in position are done actively by the patient rather than entirely through the muscular strength of the attendants. A patient who by himself moves from the recumbent position to sitting on the edge of the bed has thereby exercised to some extent most of the muscles of his arms and trunk.

If when sitting on the edge of the bed the patient is encouraged to lift his hips off the bed and swing himself further back on the bed by pressing down with his hands on the mattress, he will have exercised the same muscles used in crutch walking. A board under the mattress will give better support for these "push-ups," which can, of course, also be done in a wheel chair. The psychiatric patient must be watched carefully when on the edge of the bed lest he swing himself forward rather than backward, but it is surprising how well even those who seem far "out of contact" can do these exercises.

In addition to the active motion obtained in position changes done in this way, a basic set of exercises has been utilized. An attempt has been made to keep these as simple and as few as possible and to select ones which can be used safely in a wide variety of cases. They are easily modified to meet special needs, such as in the instance of patients with amputations, partial paralysis, etc. To emphasize the use of active rather than passive motion, instructions for active assistive exercise are not included in the written directions, but when this is indicated, the

ward personnel are shown its use in the specific instance.

Much time can be lost in getting the patient in the proper position for the exercises; therefore, they are planned to progress from prone to supine to sitting positions, which we feel is the simplest sequence. In working with a patient who cooperates poorly, however, it may be easier to progress from supine to prone to sitting positions, particularly the first few days he is on the program. The lateral position, useful particularly in exercising the extensors and abductors of the hip, is omitted in the basic program for the sake of efficiency and simplicity.

(b) *Specific exercises*

The exercises are described as follows*:

* * *

I. PRONE POSITION

The patient lies flat, face down, with the head and shoulders in a comfortable position, using a pillow if desired.

EXERCISE A

While the right knee is kept completely extended (straight), the patient attempts to extend the right hip (i. e., to raise the thigh from the bed).

The position is maintained for a quick count of three (about $1\frac{1}{4}$ seconds). The patient then relaxes completely for a count of six (about $2\frac{1}{2}$ seconds).

The left hip is then similarly extended (Fig. 1), with the same timing, this being repeated al-



Fig. 1. Exercise A. Left Hip Extension

ternately for a total of 5 to 10 times each. (Ten repetitions is the preferred total in all exercises, but excessive fatigue must be avoided: therefore, it is often wise to start with five, increasing to meet the patient's improving ability.)

This helps prevent the flexion contractures at the hip so often seen in patients who have remained in bed or in wheelchairs for a long while. It is especially valuable for lower extremity amputees. It is difficult exercise for elderly

*These are the directions as given to the nurse in charge of the ward, and are demonstrated and illustrated by cartoon type drawings in instructing the ward personnel in their use.

patients, and one need not attempt to achieve marked hyperextension; if the foot is just raised off the bed with the knee extended, this will suffice in most cases.

II. SUPINE POSITION

EXERCISE B

Lying on his back, the patient raises the right leg with the knee fully extended, holding it in this position without bending the knee for a count of three (approximately $1\frac{1}{4}$ seconds), then relaxes completely for a count of six.



Fig. 2. Exercise B. Left Straight Leg Raising

The left leg is then similarly raised (Fig. 2), this being repeated alternately for a total of not more than 10 times each.

This strengthens the flexors of the hip and the extensors of the knee. When recent hip fractures are present, this exercise is temporarily omitted on the affected side, where quadriceps setting is done instead.

EXERCISE C

Quadriceps setting is taught best with the patient sitting up enough to be able to touch his knee with his hand. It is illustrated on the sound side, the patient being told to try to "bend" the knee while the instructor prevents actual flexion by holding the leg extended on the



Fig. 3. Exercise C. Teaching Quadriceps Setting

bed. At the same time the patient's hand is placed on his patella and he is told to feel the "kneecap" move as he tries to bend the knee (Fig. 3). This is repeated with the patient's

hand on the anterior portion of the thigh to feel the muscle contraction.

This is repeated a few times on the unaffected side until the patient is able to "tighten the kneecap" on request without the leg being held for him, and is then ready to do it with the affected leg.

In performing the exercise itself, the patient may either be flat in the supine position or may have the backrest elevated. In order to avoid confusion and prevent fatigue, this and all the exercises are done with the same timing, there being active contraction for a verbal count of three (about $1\frac{1}{4}$ seconds), and complete relaxation for a count of six (about $2\frac{1}{2}$ seconds), with not more than 10 repetitions.

EXERCISE D

While lying on his back, the patient is asked to bring his right foot up to a right angle, the instructor showing him the first time by doing it passively for him.

The patient holds the right foot in the position of dorsiflexion for a count of three, then relaxes



Fig. 4. Exercise D. Dorsiflexion of Left Foot

completely for a count of six. This is repeated on the left foot (Fig. 4).

The patient is then asked to "point his toe" on the right foot, the position of plantar flexion being shown passively at first, if necessary. (Some patients who otherwise understand very poorly have been observed to learn the desired motion promptly if initially the instructor's hand is placed on the sole of the patient's foot and he is asked to push the foot down against the hand.) Plantar flexion of the right foot is held for a count of three, with relaxation for a count of six. This is repeated with the left foot.

Using dorsiflexion and plantar flexion alternately in this way helps prevent "cramps" which may occur if the patient attempts to perform dorsiflexion and plantar flexion of the same foot for 10 times without adequate rest. However, if the method described in the foregoing is too difficult for the patient to comprehend, he may instead be instructed to "move both feet up and

down" as if on the treadle of an old-fashioned sewing machine (this being a useful example for elderly female patients).

This, of course, is one of the most important exercises for a recumbent patient, as it not only helps prevent footdrop and gastrocnemius weakness, but also maintains venous return in the legs, helping prevent phlebothrombosis.

EXERCISE E

While still supine, with legs together, the patient is asked to move his right leg as far laterally as he can (Fig. 5), and return it to the mid-



Fig. 5. Exercise E. Abduction

line. He then abducts the left leg similarly, thus exercising the abductors and adductors of the thigh.

III. SITTING POSITION

EXERCISE F

The patient then sits up on the side of the bed with his legs hanging free. He is asked to straighten the right leg (extend the right knee) and hold it "straight out" for a count of three. After relaxing for a count of six, he similarly extends the left knee (Fig. 6).



Fig. 6. Exercise F. Extension of the Knee against Gravity

It is often easier for the patient to do this if he first swings his legs freely back and forth a few times.

It is more important that the knee be fully extended than that the position be held for the count of three, but this should be gradually at-

tainable in all cases of muscular weakness on a disuse basis.

If the patient supports himself with the palms of his hands flat on the bed and elbows straight while doing these exercises, the arms and back will be strengthened at the same time.

* * *

This entire group of exercises can be done before each meal, as they end with the patient sitting on the edge of the bed in a position in which he can eat. This type of timing not only assures that the program is carried out at regular intervals, but might help establish a "conditioned reflex" in the poorly oriented patient, associating exercises with meals and thus perhaps improving the motivation for the exercises as well as the appetite. (This theory has not been actually investigated by us at this time.) However, any form of regular timing permitting their performance three or four times daily may be used. It is important to emphasize that the muscle group being exercised be held completely relaxed for twice as long as it is contracted, and that each specific exercise be repeated not more than 10 times at an exercise period. This avoids muscle "cramps" and fatigue and produces a steadier gain in muscle strength. An attempt is thus made to utilize, in an elementary manner, many of the principles advocated by Kraus⁷ and others.

3. Progression from Weight Bearing to Ambulation

When the patient can do all these exercises well he is usually ready to start walking. He may actually be ready to start before then because of the difficulty of evaluating muscle strength in an uncooperative or poorly motivated patient. If he has had a hip fracture or similar disability, weight bearing is, of course, not started until approved by the orthopedic consultant.

The first step in accomplishing weight bearing is simple standing. (Before a patient is permitted out of bed he can obtain some of the physiological values of weight bearing by actively pressing with his feet against a footboard, or, if completely paralyzed or otherwise immobile, by elevating the head-end of the bed as by simply placing a chair beneath it, allowing the feet to press against a footboard by gravity.) Standing is started by having the patient stand at the foot of the bed holding on to it for support "while the bed is being made," "while a wheelchair is being brought," etc. "Reasons" such as these have been found useful in getting reluctant patients out of bed. At first the standing period may be only a couple of minutes. When the patient is able to stand at least 3 minutes in this way, "parallel bar" standing and walking is started.

Parallel bars can be readily improvised by placing a minimum of three beds closely together,

side by side, with their footboards facing those of three other similarly grouped beds. The footboards should be of equal heights, and the space between the two groups of beds should form an aisle wide enough for the patient to walk freely with his hands on top of the footboards. The patient first stands between these "parallel bars" with his hands on the "bars."

If one leg is to have only partial weight bearing, he is shown how to support part of his weight with his arms. He is then encouraged



Fig. 7. Patient Walking Between Improvised Parallel Bars

to walk the length of the three beds and return (Fig. 7). The longer the "parallel bars" the more effective walking space is provided. Although true parallel bars are easy and inexpensive to construct out of metal pipe,⁸ in an institution where space is at a premium and where patients are kept in many widely separated buildings, this use of ward beds has proven generally more practical.

The length and duration of the walking period depends on the condition of the patient. It is gradually increased. Within a few days, or by the end of not more than two weeks, the patient should be made (with reassurance and encouragement) to walk holding on to only one row of footboards, the aisle being widened or absent. At first an attendant supports the free arm and gradually, but as soon as possible, withdraws the support. Patients with no contraindication to full weight bearing are then removed from dependency on bars as soon as possible. They walk to the bathroom, with a little assistance at first. Their meals are then served a little distance away (e. g., in the dayroom instead of at bedside), and they walk to the meals.

Patients who must avoid weight bearing on one lower extremity are taught the proper gait in the parallel bars. When the upper extremities are ready to support the required weight and the patient is seen to have grasped the sequence of the gait, crutches, canes, etc., are ordered where indicated.

It is important that all ambulating patients have shoes or slippers that fit well, give adequate support, and do not have slippery soles. Crutches,

being usually of temporary use in this type of institution, are of the adjustable type, preferably with suction tips. In general, the use of crutches is more hazardous in a mental institution than in a general hospital, and we have tended to order them chiefly for young alert patients who by their aid can obtain more occupational and recreational therapy. Older patients using them are preferably on the surgical ward or other selected area where supervision is adequate and the activities of the other patients under good control.

PRECAUTION

The chief precaution in the use of any type of support including parallel bars, walkers, and the aid of attendants is to see that the patients do not use them beyond the point of necessity lest they become overly dependent on them. A very ataxic patient with an organic nervous system lesion may, of course, require some support indefinitely. Patients who because of this type of lesion cannot ambulate without walkers or parallel bars are encouraged to walk (or, at least, stand), at least twice a day in this manner even if the rest of the day is spent in a chair. This is for the psychological and physiological reasons stated previously.

The management of mental patients with *special problems* such as hemiplegics, amputees, paraplegics, etc, will not be discussed in detail at this time. The same general principles are applied as in the rehabilitation of mentally normal patients with these disabilities. These principles have been adequately discussed in numerous articles by Rusk,⁹ Abramson,¹⁰ Dacso,¹¹ and other authorities in this field. Methods are adapted to the needs and aptitude of each patient, considering available facilities and personnel. With ingenuity and patience much can be accomplished.

The chief obstacle to obtaining and maintaining ambulatory patients in a mental institution is a defeatist attitude on the part of the personnel. There is a great tendency to assume that a patient is *unable* to do something just because he has not done it in the past. We have seen numerous "completely bedridden" patients become completely ambulatory under the guidance of patient, cheerful, optimistic personnel. The major part of this was accomplished by attendants who had no previous training in physical therapy, using simple methods such as those outlined above. It is felt that with continued encouragement and education progressive improvement will be seen in the total rehabilitation of the mentally ill.

SUMMARY

The need for attaining ambulation in "bedridden" psychiatric patients is discussed. A program applicable to mentally ill patients with medical and surgical complications is outlined. This program is designed to be safely utilized in institutions having a shortage of trained per-

sonnel and of the usual facilities for physical rehabilitation.

Acknowledgment: Miss Grayce L. McVeigh, R.N., Assistant Director of Nursing Services, Dayton State Hospital, assisted in the application of this program. Photographs were taken by Miss McVeigh and Dr. T. H. Sills.

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Control of Brucellosis in Livestock By Immunization

In *Brucella abortus* infection there are two main methods of control. One resembles that in common use in the control of bovine tuberculosis, namely, the detection of infected animals and their removal from contact with healthy livestock, although the tests applied are quite different. The other embraces the use of suitable vaccine. . . .

Although it has been possible to eradicate brucellosis from herds of cattle and even from areas of countries in the earlier stages of a campaign for the eradication of the disease, by detecting and removing infected animals, the incidence of the infection and the highly infective nature of the causal organism make it difficult to prevent re-infection of a herd.

Recourse has, therefore, to be made to the protection of livestock by immunization. There are now available vaccines with high protective values and one especially is now being used throughout many parts of the world. This is a strain of *Br. abortus* of natural low virulence which, when injected into susceptible animals sets up an immunity of high order against brucella infection. The vaccine is used in the living state and, although effective in bovines of all ages, is largely used on young stock.

It has recently been shown that a single dose of the vaccine injected into young female bovines will give protection against natural infection of average virulence for four or even five pregnancies. This means that in most instances the protection so acquired remains during the whole of the animal's economic life.—Sir Thomas Dalling: *Healthy Animals Mean More Food*. *WHO Newsletter*, 8:1, Nov. - Dec., 1955.

Environment and Mental Illness:

A Study of Urban-Rural Differences in Social Organization

ROBERT M. FRUMKIN and MIRIAM Z. FRUMKIN

ABOUT 85 per cent of the United States population was rural in 1850. Since that time, however, the rural population has become smaller and smaller. Thus, in Ohio in 1950, only 29.9 per cent of the entire population was considered to be rural. Although the trend in population movement seems to be away from the centers of cities, what has been called by some a movement toward "rurbanization," the ideology of the city, urban values and behavior have extended their increasing influences upon rural people. Many people who live in rural areas now hold urban jobs and have adopted the urban philosophy of life.

In a study of suicide in a Northwestern state, it was found that rural rates were significantly higher than urban rates. Since this finding was contradictory to the results in other studies, a further examination of these rural suicides was undertaken. It was then found that the overwhelming majority of these rural persons had been employed in urban occupations and worked in urban areas.

Few research investigations in social psychiatry have probed the problem of environment and mental illness, especially as urban and rural residence relate to the various mental illnesses.

It is the purpose of this study to obtain data not only on the urban-rural differences which might exist in the prevalence of mental illness, but also the differences in particular types of mental disorders.

METHODOLOGY

In order to ascertain the relationship between environment and mental illness, the 1948 admissions with major mental disorders to Ohio State mental hospitals were broken down statistically by mental disorder and environment (urban and rural residence) at the time of admission. From these data indices of prevalence of mental disorders among urban and rural populations were determined with the aid of the 1950 census of Ohio. An index of prevalence is equal to the ratio of individuals in the hospital population to the individuals in the entire population with reference to a particular characteristic. This ratio is multiplied by 100 to get an index in whole numbers. If both populations are alike with reference to a particular characteristic the

Submitted July 29, 1954.

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index would be 100. If unlike, either more or less than 100.

FINDINGS

The major findings of this study are summarized in table 1.

TABLE 1—INDICES OF PREVALENCE OF MENTAL DISORDERS AMONG URBAN AND RURAL POPULATIONS

Mental Disorder	Indices	
	Urban	Rural
Total	115	67
Syphilitic Psychosis	120	52
Alcoholic Psychosis	120	53
Psychosis with CAS*	116	63
Senile Psychosis	113	69
Involuntional Psychosis	115	65
Manic-Depressive Psychosis	106	87
Schizophrenia	113	69
Paranoid Conditions	123	45
Psychoneurosis	109	80

*Cerebral Arteriosclerosis.

Upon examination of Table 1 one striking fact becomes immediately apparent—namely, the high prevalence of mental illness among urban individuals.

Within each population, however, there can be seen differences in the rank of the various major mental disorders. Thus, among urban individuals paranoid conditions predominate. Syphilitic and alcoholic psychoses are also common. But in the rural population we find that manic-depressive psychosis and psychoneurosis lead the field.

DISCUSSION

The general differences in rates of mental illness among urban and rural populations are explained largely by the concepts of social organization and personal maladjustment first advanced by Durkheim in his classical study of suicide.¹ Durkheim posed the hypothesis that the social cohesion of the group (or groups) to which an individual belonged and identified himself with

was inversely related to the prevalence of personal maladjustment which leads to suicide. Thus, he found that rural populations had lower rates of suicide than urban populations. It was the *anomie*, the social disorganization in urban groups which led to higher urban rates. This concept of *anomie* explained why rates of suicide are high during periods of depression, low during war time, high among the divorced, low among orthodox religious groups, et cetera.

Sociologists have emphasized the fact that urban communities show less social cohesion and more *anomie* than rural communities. In rural communities primary groups are the predominant influence, whereas in the city their influence is constantly being replaced by other, largely secondary, groups. In the city, individuals are isolated electrons, a lonely crowd; in the rural community, individuals are electrons which have an integral place in the orbits of a highly cohesive social organization (an atom).

The "East Sides" of urban communities are filled with houses of prostitution and other loci of demoralizing vices. Liquor stores are more common than grocery stores. It is thus no wonder that rates of alcoholic and syphilitic psychosis are higher in urban populations. The greater availability of alcoholic beverages in cities makes alcoholism and alcoholic psychosis more prevalent than in rural areas.

The status consciousness of the city dweller who seems eternally seeking upward social mobility makes him an easy victim of persecutory or grandiose delusions which are manifested in paranoia and other paranoid conditions. Thus, it is not surprising to find that the less status conscious rural individuals have three times less paranoid conditions than are found among city people.

BASIC URBAN-RURAL DIFFERENCES

But why do rural individuals have higher rates of psychoneuroses and manic-depressive psychosis? One hypothesis which seems to be promising here is that suggested by Joseph Eaton's study of the Hutterites.² In this rural Non-Marxian communistic, isolated Protestant religious sect Eaton found a low incidence of mental illness. Again, as in other rural populations he found high rates of manic-depressive psychosis and psychoneurosis. He and his colleagues suggest that repression of guilt might be an etiological factor in both of these mental disorders. Since most rural populations are fairly rigid in their religious ideology and foster a great deal of guilt which can't be as easily dissipated as can be done in the city, the moods of depression and elation (in manic-depressive psychosis) and the anxieties as found in psychoneurosis are common within that population.

It is contended that rural individuals have greater "social feeling" or social consciousness than urban individuals because they live more in

cooperation with their neighbors than in competition with them. Thus, violations of the social code of the rural community is a social "crime" for which the individual feels guilty. Perhaps this is why the upper strata of society, in which the family name and reputation are exceedingly important, have higher rates of manic-depressive psychosis and psychoneurosis within their groups than do the lower strata of society. It seems also that the very high rates of manic-depressive psychosis among managerial workers (who have a high degree of social consciousness or feeling) are due to the same guilt factors found in the etiology of this illness in rural people.

The compulsiveness of the urban individual and the corresponding spontaneity in rural individuals might also suggest why involuntional psychosis shows higher rates among urban than rural individuals. Involuntional psychosis is most common among compulsive personality types.

The lower incidence of the psychoses of old age among rural people might be due to the fact that aged rural people still have a place in their families and communities and are not considered burdens to their families. There are things for old folks to do and a place for them to live. In the city old folks lose prestige and status once they have retired and are considered a financial burden. There is no room for old people in the city.

In the city, more so than in rural areas, frustrations in a highly competitive environment are more frequent. They often result in the isolation of the individual, press him to lose contact with his environment, and lead to the bizarre personal worlds typical of the schizophrenic. In rural communities the cooperative spirit of brotherly love often counteracts serious frustrations and hardships that individuals encounter. Rural people have a better sense of security in times of trouble and can depend on neighbors to be good neighbors when needed most. In the city it is not uncommon that one doesn't even know the name of his next door neighbor.

SUMMARY

This study of urban and rural populations and mental illness reveals that: (1) Urban individuals have higher rates of mental illness than rural people; and (2) That rural mental illness seems to be most commonly a manifestation of guilt and social feeling, whereas urban mental illness seems rather to be a manifestation of highly competitive, commercial, "business-is-business" type of environment.

It is contended that the urban individual would do well to learn some of the cooperative behavior of the rural people in order to raise his level of mental health. Increased "rurbanization" might thus be a step in the right direction.

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The Treatment of Gonorrhea with Oxytetracycline* Intramuscular

OLLIE M. GOODLOE, M. D., M. P. H., and LOUIS J. ROTH, M. D.

THE search for a good substitute for penicillin in the treatment of gonorrhea stems from an increasing sensitivity to this drug. In clinics where the great majority of the patients are indigent, it is impractical to prescribe antibiotics by mouth, not only because of the cost but also because many patients fail to follow instructions. In addition, the epidemiological aspect of this slower form of treatment adds to the incidence of gonorrhea.

PROCEDURES

Oxytetracycline powder 100 mg. and 100 mg. of magnesium chloride hexahydrate in 2 per cent procaine was made available to us. This mixture was dissolved in 2 cc. of distilled water and the solution was injected deeply into the muscle of the buttock. On experiment, however, it was found that the 2 cc. solution, containing 100 mg. oxytetracycline, did not effect a large percentage of cures in the number of patients treated. The dose was then doubled, the full 4 cc. being injected into one buttock. This was found to be so painful that the dose was divided and 2 cc. injected into each buttock. Smears were made before and after treatment.

Fifty-nine cases of acute gonorrhea were given this treatment. Results are shown in table 1.

TABLE 1—RESULTS

No. of patients	Amount given	Positive smear after treatment	1 Negative smear	2 Negative smears	Did not return after treatment
5	100 mg.	2	1		2
54	200 mg.	13	18	12	11

The percentage of results after one treatment were, as follows: 25.4 per cent continued positive, 32.2 per cent had only one negative smear, 20.3 per cent had two negative smears. The results in 22 per cent of the cases were unknown because patients did not return for follow-up. Let us assume that the 13 patients who did not return for further treatment were cured. In this case, the percentage of cures would be 74.5 per cent.

OBSERVATIONS

A large percentage of patients who returned positive, after treatment, admitted drinking some alcoholic beverage. All of these patients denied further exposure. Those patients who were cured showed the same amount of nonspecific urethritis

Submitted January 31, 1955.

*Oxytetracycline is terramycin®, which was furnished to us through the courtesy of Chas. Pfizer and Company.

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after cure as we find in a penicillin cure. There were no cases of induration or abscess formation following the injection; no systemic reactions or skin reactions occurred. The injections were always more painful than penicillin.

CONCLUSIONS

If it were possible to increase the dosage and lower the painfulness of this drug, the results in the treatment of gonorrhea might approach or equal that of penicillin. The effectiveness of oxytetracycline, in its present dosage, can be influenced by the use of alcohol. However, in patients, who are penicillin-sensitive and who cannot afford an antibiotic by mouth, it is the best choice of treatment for gonorrhea.

SUMMARY

1. The increase of penicillin sensitivity has heightened the search for an intramuscular injection for the cure of gonorrhea.
- 2 Oxytetracycline injectable, with 74.5 per cent cures, is an approach in this direction.

Usual Methods Found Impractical In Suppressing Psittacosis

The present nature of the bird trade makes it impractical to suppress the spread of psittacosis by the usual public health control procedures.

Only the building up of breeding establishments free from the infection will ultimately reduce the large reservoir—a constant source of infection to the purchasers of pet birds. There is encouraging evidence that this goal may be reached by chemotherapy of the breeding flocks.

It is puzzling that despite educational programmes the public continues to purchase pet birds without enquiring into the general condition of the stock. People do not become alarmed until, a few days after the bird has been in the house, it suddenly sickens and dies—after the whole household and anyone who has entered it have been thoroughly exposed.—Dr. K. F. Meyer: Warning to Cage Bird Buyers, *WHO Newsletter*, 8:4, Nov. - Dec., 1955.

Low Back Pain

BEN R. WILTBERGER, M.D.

BECAUSE low back pain is one of the most common afflictions of mankind, this discussion will be limited to pain of the low back region.

As a result of modern conveniences identified with the American way of life, extensive industrialization, and an increase in all means of transportation, the incidence of back complaints and injuries has increased considerably during the past two decades.

During the past ten years the majority of authorities have changed their concept of low back pain and its causes and have completely eliminated such diagnoses as lumbago, sacro-iliac and sciatica. It is now the consensus of opinion among such doctors as Doctors MacNab, Harris, Key, Kimberly, Caldwell, Shutkin as well as many others, that, percentage-wise, the intervertebral disc is involved in the large majority of cases of idiopathic low back pain, and they divide the pathology into degenerated lumbar discs and ruptured intervertebral discs.

ANATOMY OF LOW BACK REGION

To understand the etiology and pathology of low back pain, one must review briefly the anatomy of the low back region. The vertebral bodies are separated by cartilaginous cushions which have a rubber-like consistency. Attached posteriorly to each vertebral body is a signet-like ring of bone comprising the laminae, the transverse processes and the spinous processes as well as the very important posterior articulations called facets. The cauda equina runs distally from the level of the second lumbar vertebra down into the sacrum and opposite each intervertebral disc and the posterior articulations off into a foramen or opening into the musculature at the side of the spine. These nerve roots then collect and comprise the sciatic nerves bilaterally.

Doctor Roger Anderson has written that the main difference between the joints of the spine and other joints of the body is their close proximity to these nerve roots so that any injury to the bones or joints, or any disease of these bones or joints cause symptoms of a neurological nature. Also, in considering the anatomy of the back, one must keep in mind that the vertebral bodies and joints are supported by a mass of muscles and ligaments and that any weakening or atrophy of these muscles or ligaments has a secondary effect on the vertebral body, the intervertebral disc and the posterior articulations called facets.

Since most cases of low back pain are from

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either a ruptured intervertebral disc or a degenerated intervertebral disc, let us consider the predisposing causes of these two conditions. It is a well known fact that certain families have weak intervertebral discs and the members of these families tend to injure their backs easily and also tend to have a more rapid rate of degeneration of their intervertebral discs. The incidence of disorders of a disc is also greater among people from 20 to 50 years of age and is more common in the male than in the female because in his life, he is more subject to trauma.

Although both the ruptured intervertebral disc and the degenerated intervertebral disc are, in reality, abnormalities of the same structure, they will be discussed separately because they manifest themselves by different symptoms and are treated in a different manner. Most pathologic changes of the disc occur in the last two joints of the spine, between the fourth and fifth lumbar vertebrae and between the fifth lumbar vertebra and the sacrum, and these two joints constitute 96 per cent of the pathologic findings in intervertebral disc disease or injury. About 2 per cent is found between the third and fourth lumbar vertebrae and only 2 per cent in the remaining portion of the dorsal and lumbar spine.

Doctor J. R. Armstrong in London, England, Doctors Harris and MacNab in Toronto, Canada, and Shutkin in the United States, along with many others, feel that several factors work together to cause the degeneration of a lumbar disc. These factors are the familial incidence as mentioned before, repeated minor trauma to the spine or any one severe trauma to the low back region. Thus, trauma can either precipitate a degeneration of a lower lumbar disc or be an aggravating factor in a pre-existing degenerated lumbar disc in the low back region.

As this disc degenerates, the vertebral bodies settle so that they move closer together and, frequently, because of the inclined plane of the posterior articulation, the uppermost vertebral body will move posteriorly on the lower vertebral

Submitted December 15, 1954.

body or sacrum, thus causing an incongruity or telescoping of these posterior articulations referred to as facets. Along with this telescoping or incongruity of the facets, the lowermost facet then moves up into an abnormal position protruding into the foramen or opening between the vertebral bodies where the nerve root emerges, and because of this, there may be nerve root compression. Accompanying the incongruity and telescoping of the facets, there is abnormal wearing of the articulations of the facets which leads to traumatic arthritis of these joints which in turn cause edema or swelling about these joints resulting in additional nerve compression due to the close proximity of the joints to the nerve roots.

TYPICAL CASE OF DEGENERATION OF LOWER LUMBAR DISC

The following is a typical history, physical examination and x-ray examination as found on a patient with a degenerated lower lumbar disc:

A person usually between the ages of 20 to 50, more likely to be a male than a female, presents himself to the physician and gives a history of having an insidious onset of low back pain after minimal repeated trauma or, an acute onset after a more severe type of trauma. Following this onset of pain, he has found that any increased activity increases the low back pain. Frequently the patient will have a radiation of pain down the posterior aspect of both thighs, usually as far as the knees, and this pain is relieved by heat and rest and aggravated by activity.

Examination of such a person usually reveals no flattening out of the normal curve of the lower lumbar region, limitation of motion of the lumbar spine in all directions, tenderness over the lower lumbar region as well as tenderness in the region of the buttocks, which may be bilateral, and there may be bilateral posterior thigh tenderness. Forced flexion of either hip so that the thigh is flexed on the abdomen moves the lumbosacral articulation and the lower lumbar articulations and causes pain in this region. Also, flexion, abduction and external rotation of the hip joints causes a positive sign of pain in the lower spine region similar to the previously described test of flexion of the thigh on the abdomen.

Both legs are found to be neurologically negative in contrast to what is found in regard to neurological changes in the legs when a patient has a ruptured disc. By being neurologically negative, one means that the reflexes are normal, and there is normal sensation of both lower extremities.

Roentgenograms of a degenerated disc with back pain would probably reveal a narrowing of either the next to the last or the last intervertebral disc space, a displacement posteriorly of the upper vertebra posteriorly on the lower vertebra or, in the case of the last, posteriorly on

the sacrum. Oblique views would show a telescoping or subluxation of the facets of the level of the disease as well as sclerosis of these facets.

The treatment of this condition in its acute phase consists of complete bed rest with the spine in a flexed position and traction of approximately five pounds on both lower extremities, as well as sedation for pain. After the acute phase has subsided, the patient is allowed to be ambulatory and some form of external support such as a chair back brace or a lumbosacral belt with rigid steel stays is prescribed. After all symptoms of pain have subsided, the patient is placed on a gradually increasing regime of muscle building exercises such as the Williams exercises or a gradual increase in normal exercises, such as swimming, in an effort to build up the recti muscles of the abdomen, the gluteal muscles of the buttocks, the hamstring muscles of the thighs and the erector spinae group of muscles of the low back region.

In some severe or persistent cases of pain in the low back region due to a degenerated lower lumbar disc, a distraction type spinal fusion will sometimes be necessary. This is a bone grafting operation of fixing one vertebra to the other while held distracted, thus opening the foramen or opening for the nerve root.

RUPTURED INTERVERTEBRAL DISC

A true, ruptured, lower lumbar, intervertebral disc is usually a bulging or herniation of the posterior lateral aspect of the intervertebral disc so that it protrudes and presses on one or more nerve roots. Thus, the nerve root pressure is a primary compression of the diseased tissue itself, rather than a secondary compression as found in a degenerated disc when the vertebral bodies move together causing a telescoping of the facets and a closing down of the foramen on the nerve root. This primary compression, or ruptured disc, might be compared to a blowout on an automobile tire in that when it is observed surgically, there is found to be a bulging-out posteriorly, or posteriorly laterally of the actual disc tissue. Many times the nerve root involved is found to be inflamed and stretched tightly over the bulging protruded disc.

It is the opinion of Doctor J. Albert Key, Doctor Francis Murphy, and others, that minor ruptures of intervertebral discs are probably the most common cause of low back pain without leg radiation, for disc tissue itself has a nerve supply and when the disc is torn and stretched only a slight degree it registers pain only in the back. Then, as the protrusion increases and there is pressure on a nerve root, the pain begins to radiate down the leg.

TYPICAL CASE

The following is the typical history, physical examination and x-ray examination which one

might expect to find on a patient with a ruptured intervertebral disc:

This patient is more likely to be a male, usually between the ages of 20 to 50. He gives a history of having experienced several subacute attacks of low back pain brought on by trauma; each attack becomes more severe than the last. Usually, as the attacks progress, there will be more radiation of pain to the leg. However, a patient might give a history of severe trauma causing an acute onset of excruciating low back pain accompanied by pain radiating down one or both legs extending sometimes as far as the toes. This pain is of a burning, electrical-like nature, and is often described by the patient as being similar to the sensation experienced when a dentist injects a nerve to deaden a tooth.

The pain from an acute, ruptured, intervertebral disc is usually so severe and incapacitating that it is necessary for the patient to be completely immobile for a period of days or weeks. It is typical for this type of disc pain to be periodic, and the patient may become symptom free for days or weeks at a time only to have a recurrence of the pain at a later date. For this reason the same individual may be examined by two competent orthopedic surgeons on different dates with varying physical findings, a fact which is difficult for attorneys and jurists to understand.

A patient with a typical, ruptured, intervertebral disc also gives a history of a listing of the spine in the lumbar region to one side or the other. This list may be to either side. However, it is more likely to be to the opposite side from which the pain radiates into the leg. The patient also usually notices that coughing, sneezing and straining at stool causes a severe radiation of pain down the leg, and he will notice areas of numbness over typical, neurological, anatomical patterns down the leg. Also, he may notice a weakness, or giving-out sensation, of the leg particularly when he is fatigued. Lifting, bending, stooping, standing and riding in an automobile, as well as any other excessive activity, seems to cause an exacerbation of the symptoms of an acute, ruptured intervertebral disc.

Examination usually reveals a patient in a marked degree of distress, holding his back stiff, and walking with a limp. A loss of the normal lumbar lordosis will usually be found, so that the lower, lumbar spine region is completely flattened out, and when requested to bend forward, he leans like a straight stick. Many times the list of the spine will be quite noticeable so that the patient leans forward and to one side as he walks. In fact, there is a common saying among orthopedists that if a patient has a list, he has a disc. Further examination of the spine reveals marked muscle spasm, and marked limitation of motion of the spine usually

in all directions, but particularly toward the side of the leg pain.

Frequently, quite severe lumbosacral tenderness is found, or tenderness over the involved disc. There is tenderness in the buttocks region on the side involved and tenderness over the posterior aspect of the thigh and calf on the side involved. When the patient's outstretched leg on the bad side is raised by the physician, it will cause a severe radiation of pain down over the nerve root involved often as far as the heel or foot. The ankle reflex on the side involved is commonly found to be reduced, particularly if the interspace involved is between the last lumbar vertebra and the sacrum. Sometimes it is found that the knee reflex is reduced, particularly if the interspace involved is between the third and fourth lumbar vertebrae or between the fourth and fifth lumbar vertebrae.

Commonly, the physician is able to map out a typical nerve root pattern, the most common being the first sacral nerve root which supplies the sensation to the outer aspect of the lower calf and the outer aspect of the foot, usually involving the last two or three toes. Frequently, the fifth nerve root is involved and this nerve root supplies the anterior aspect of the lower leg and the dorsal aspect of the foot into the large toe of the foot. Since between 5 and 15 per cent of ruptured discs may be multiple, or involving two discs, both of these nerve root patterns are, at times, found to be deficient.

Roentgenograms usually reveal a list of the lumbar spine, a loss of the normal curve of the lumbar spine on the lateral view, and if the ruptured disc is of long standing, some narrowing of the interspace involved is noted. However, if it is a new ruptured intervertebral disc, there will likely be no narrowing of the interspace, and many times such roentgenograms are read as negative. These films could be reported negative in spite of the fact that the patient has a true intervertebral disc clinically.

About 80 per cent of the cases of ruptured, intervertebral discs can be demonstrated by the special technique of a myelogram. It must be kept in mind, however, that about 20 per cent of all myelograms are negative in spite of the fact that there is a definite ruptured intervertebral disc, and that a negative myelogram does not mean that the patient does not have a ruptured disc nor, if he is sick enough, that he should not be subjected to an operation.

Most orthopedic surgeons have found that attorneys, juries, and insurance companies rely too heavily on myelograms for diagnosis of a ruptured intervertebral disc, and not sufficiently on the clinical findings and histories of such a condition. Many times a very sick person, because of a negative myelogram, may receive neither proper medical attention nor a fair verdict by jury.

Eighty to ninety per cent of the cases of

ruptured intervertebral discs can be treated conservatively. This conservative therapy consists of complete bed rest for several weeks, infrared bakes and massage to the low back region three times a day, muscle relaxing drugs such as tolserol® and curare, and traction to the legs in an effort to distract or pull apart the vertebral bodies so that the protruding intervertebral disc will flatten out and cause less nerve compression.

After several weeks of conservative therapy, the patient should gradually be made ambulatory in a well fitting external support such as a chair back brace or a lumbosacral belt with rigid steel stays. If the patient becomes symptom free after wearing a brace or corset for several months, he will, as in the case of the degenerated disc, be placed on a regime of Williams exercises, or a gradual increase in normal exercise, such as swimming, in an effort to build up his musculature. Following this, the external support should be removed if possible.

It should be remembered that a person with a true history of a ruptured intervertebral disc has a permanent disability in spite of the fact that he may become symptom free because, even if the discs heals with scarring, it is potentially weak and is very likely to be re-injured.

SURGICAL TREATMENT

If conservative therapy fails after several weeks, or the patient has repeated acute episodes of very incapacitating attacks from his ruptured intervertebral disc, or if, as is found in 2 per cent of the cases, he begins to have paralysis of one or both legs, he should then submit to a laminectomy and surgical removal of the ruptured intervertebral disc. It must be kept in mind, however, that this operation is far from 100 per cent successful in regard to curing all patients. It is an established fact that such surgery cures only about 55 or 60 per cent of the cases. However, it will improve about 85 to 92 per cent of the cases.

Several factors determine whether a patient should have just a laminectomy or a spinal fusion along with a laminectomy. If the patient has no evidence of a telescoping of the articulations as mentioned in the degenerated disc, no traumatic arthritis of the articulations, and no narrowing of the disc space and he does not have to perform heavy labor, it would probably be wise to do only a laminectomy. If the patient has any one of the aforementioned pathological conditions, or does heavy labor, or if, at the time of surgery, it is found that his spine is very unstable, then a spinal fusion of the distraction-type is indicated in an effort to prevent a telescoping and incongruity of the posterior articulations and secondary nerve compression in the nerve root opening or foramen due to these

degenerative changes of the posterior articulations.

REHABILITATION PROGRAM

Even after a rather successful laminectomy, or laminectomy and spinal fusion, it is frequently necessary for the patient to change his occupation if he does heavy work, for it is the author's opinion that in spite of successful surgery, there is usually some residual disability after a disc operation. This permanent disability can be lessened as the years pass by a regime of graduated muscle building exercises to strengthen the abdominal muscles, the back muscles, the buttocks muscles and the leg muscles. Because of this fact, many patients will benefit from a rehabilitation program.

OTHER CAUSES OF LOW BACK PAIN

Although degenerated discs and ruptured discs constitute a large majority of the causes of low back pain, there are other causes of low back pain which will be discussed very briefly as it is not within the realm of this paper to dwell too deeply into the many causes of back symptoms. Of the remaining causes, the most common is hypertrophic arthritis. This is most frequently found in patients after the age of 50 who do laboring work. It manifests itself by stiffness of the low back region, pain in the low back region and often, pain around onto the abdomen and down into the thighs. These symptoms are aggravated by activity and are more acute in damp, cold weather. Roentgenograms of a patient with this condition reveal multiple spurs of bone lipping over the edge of the bones much as tallow on a candle. The treatment of this condition consists of heat, rest, salicylate medication and a chair back brace or a lumbosacral belt with rigid steel stays.

MARIE-STRÜMPPELL ARTHRITIS

The least common type or rheumatoid arthritis of the spine goes under the name of Marie-Strümpell arthritis. This disease is a constitutional disease as are other forms of rheumatoid arthritis, and it is usually found in the younger age group. These patients have the typical poker-back spine, a limitation of expansion of the chest which is one of the first objective findings in this condition, and on x-ray examination are found to have first a sclerosis of the sacro-iliac joints then later, a sclerosis of the the facets starting at the bottom and climbing up the spine. Complete bridging together of the vertebral bodies is the end result of this condition.

Treatment of this condition is primarily a medical problem as the constitutional symptoms of rheumatoid arthritis are treated with cortisone, salicylate medication, gold therapy and blood transfusions. The local treatment consists of x-ray therapy along with a Taylor back brace.

The Taylor back brace prevents curving forward of the spine into a humpback position.

SPONDYLOLISTHESIS

Another condition which causes definite low back pain is spondylolisthesis. At present, this is thought to be either congenital or a birth injury resulting in a fibrous union, instead of the normal bony union, in the posterior elements of the lower lumbar spine at the level involved. In this condition there is a slipping forward of the upper vertebra on the lower one since they are not held together by the bony structures of the posterior elements present in a normal spine. The symptoms of this condition consist of back pain with radiation of pain down one or both legs, a step-off deformity at the lumbosacral level posteriorly and a closer than normal approximation of the lower ribs to the pelvic bones bilaterally. The most important factor is a positive x-ray of the defect in the posterior elements of the vertebrae so that the upper vertebra slips forward on the lower vertebra in varying degrees.

The treatment of this condition is muscle building exercise and a chair back brace. If this conservative therapy is unsuccessful then, following the method of Doctors Gill, Mannering, and White, a complete excision of the posterior elements of the involved vertebra with a freeing of the nerve roots at that level is carried out with, or without bone grafting of the vertebral bodies.

Other causes of low back pain are congenital defects such as asymmetrical facets, congenital absence of facets, transitional fifth lumbar vertebrae or first sacral segments, hemivertebra, and spina bifida. Each of these conditions are diagnosed by x-ray, and each treated according to the magnitude of the symptoms either by conservative methods as aforementioned or surgical methods such as by a spinal fusion.

Acute bacterial infections such as tuberculosis, brucellosis, and common osteomyelitis of a pyogenic organism as well as benign bone tumors such as an osteoid-osteoma, hemangioma, osteochondroma and, of course, malignancies, either primary or metastatic, must always be considered in making a diagnosis in a case of low back pain. The symptoms of these conditions are usually of increased magnitude as compared to the more common conditions causing low back pain. Each of these conditions must be treated separately. However, it is not within the realm of this brief paper to discuss each type of treatment.

A not too infrequent cause of low back pain is on the basis of a disease of the visceral abdominal organs such as the gallbladder, the bowel, the genito-urinary system and the pelvic organs. These conditions cause pain of a referred nature and it is often referred to the low back region. Of course, the treatment of this low back pain depends on eradication of the disease of the particular organ.

Another condition occasionally seen in the low back is senile osteoporosis. As the name indicates, this is a condition of the aged which occurs when the sex glands fail to produce the hormone secretions which the body needs to keep the bones hard and firm. These bones then fracture easily, and one often sees multiple fractures of the spine accompanied by severe pain with secondary radiculitis of nerve pain around the body. This condition is treated, with good results, by supplying sex hormone secretion artificially, and wearing a back brace for several months.

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The Status of Corticosteroid Therapy in Dermatology

Therapy with systemic corticosteroids, despite attendant serious risks, is mandatory in diseases such as pemphigus, acute disseminated lupus erythematosus and some cases of exfoliative dermatitis that are ordinarily fatal, for in such cases life may be prolonged and the patients made comfortable.

If no contraindications exist, therapy with corticosteroids is desirable for diseases of short duration—contact dermatitis, serum sickness reactions, and drug eruptions of all kinds—provided the causative factors have been removed and the reactions are causing severe distress.

More often than not, hydrocortisone ointment and lotions benefit more than do other standard remedies such diseases as atopic eczema, contact dermatitis, lichen simplex-chronicus and eczematized phases of conditions such as psoriasis and superficial mycotic infections.

Preparations containing a combination of hydrocortisone and an antibiotic are more useful than hydrocortisone alone.—Herbert Rattner, M. D., Chicago: *California Medicine*, 83:331, November, 1955.

Management of Conjunctivitis

WILLIAM H. HAVENER, M. D.

FROM a therapeutic standpoint, conjunctivitis may be subdivided as follows: (1) Infectious types susceptible to antibiotic therapy. (2) Allergic types responding to cortisone therapy. (3) Indeterminate whether (1) or (2), and therefore treated with combined antibiotic-cortisone drops. (4) Minor irritations, responding well to nonspecific astringent therapy. (5) Types indicating a more serious, and often systemic, disease. (6) Conjunctival hyperemia secondary to serious eye diseases. (7) Traumatic conjunctivitis.

BACTERIAL CONJUNCTIVITIS

(1) Among the many antibiotics available for topical ocular use are 0.5 per cent terramycin,[®] 0.5 per cent aureomycin, 0.5 per cent chloromycetin,[®] 0.5 per cent streptomycin, 0.5 per cent neomycin, 30 per cent sulfacetimide, furacin[®] 0.02 per cent, bacitracin 500 units/cc, polymyxin B 10,000 units/cc, and 4 per cent gantrisin.[®] In solution, many of these deteriorate rapidly, some losing their potency in less than one week, with the notable exception of sulfacetimide which is indefinitely stable. Ointment preparations are quite stable and have the advantage of longer contact with the eye; however, the precorneal ointment film causes some indistinctness of vision, the lids tend to become greasy, and ointment instillation into children's eyes may be difficult.

Ointments are ideal for use in cases with associated infection of the lid margins, and should be applied every hour or oftener, after thorough removal of crusts with hot compresses. To maintain effective drug concentrations, drops should be prescribed every 1 to 2 hours during the day.

Almost 5 per cent of patients will develop a local allergy to penicillin, which therefore should never be prescribed for conjunctivitis. Theoretically, antibiotics for topical application should be those which are not used systemically, in order to avoid development of drug-fast bacteria and sensitization of patient. Thirty per cent sulfacetimide stings briefly and children, especially, object to it; nevertheless there is frequently gratifying relief from ocular irritation following the initial brief smarting.

Any of the above antibiotics will be found quite efficacious against the average bacterial conjunctivitis. Streptomycin is, of course, reserved for gram-negative infections. Not all bacteria are destroyed by antibiotics, which are not exceptions to the rule that contaminations of droppers and bottles must be avoided. The old standby, yellow oxide of mercury, is a very inefficient antibacterial agent and should be considered obsolete. Eye pads promote bacterial growth and are therefore contraindicated in acute bacterial conjunctivitis.

Submitted August 30, 1954.

The Author

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Failure of an acute conjunctivitis to respond to antibiotics used every 1 to 2 hours for 2 to 3 days usually means the diagnosis is not conjunctivitis, but falls into type 5 or 6 of our classification.

ALLERGIC CONJUNCTIVITIS

(2) Cortisone ophthalmic suspensions of 0.5 per cent and 2.5 per cent and ointment 1.5 per cent are commercially available. Most cortisone suspensions tend to settle out, so must be shaken before use. Although cortisone is quite stable, crystal size increases in old preparations, and some patients will complain of mechanical irritation due to these small particles. White crusts of cortisone form on the lid margins, but are readily removed with moist cotton. Virus growth is believed to be facilitated by cortisone and an absolute contraindication to its use is the dendritic corneal ulcer of herpes simplex. Corneal vascularization and scarring is inhibited by cortisone.

Except in unusually severe processes, 0.5 per cent cortisone is practically as efficacious as 2.5 per cent and considerably less expensive. An occasional patient responds better to hydrocortisone than to cortisone. Systemic administration of cortisone or ACTH is not necessary in conjunctivitis, since this region is freely accessible to topical medication. Inasmuch as cortisone suppresses symptoms rather than cures the disease, it is often necessary to continue therapy for prolonged periods of time. To obtain maximal response frequent instillation is required—every 1 to 2 hours. Frequency of use may *gradually* be reduced after acute symptoms are controlled, however, administration three times daily is commonly required for some months. Cases relapsing due to too rapid withdrawal do not become resistant to subsequent cortisone therapy.

An ophthalmic antihistamine preparation, antistine,[®] is useful for the watery, red eye associated with hay fever.

ETIOLOGY INDETERMINATE

(3) Not infrequently a secondary infection becomes superimposed upon an allergic process, or there may be uncertainty as to whether a par-

ticular case of conjunctivitis is bacterial or allergic. Combined therapy is effective, but because of the unnecessary expense to the patient should not be prescribed indiscriminately in a "shotgun" manner for clear-cut bacterial or allergic conjunctivitis. Among these preparations are cortisone 0.5 per cent combined with sulfacetimide 15 per cent; neomycin 0.5 per cent, cortisone 0.5 per cent; and, of course, prescriptions may be written for any other antibiotic-cortisone combination. During the acute stage of a conjunctivitis the patient should use these drops every 1 to 2 hours.

IRRITATIVE CONJUNCTIVITIS

(4) Astringents such as 0.25 per cent zinc sulfate are useful alone or in combination with 1:1000 adrenalin® as nonspecific therapy for mild chronic hyperemia and irritation after bacterial causes have been ruled out. Adrenalin® will also give symptomatic relief of allergic manifestations. Cold moist compresses may be applied for 5 to 10 minutes as often as necessary for comfort.

CONJUNCTIVITIS WITH SYSTEMIC DISORDERS

(5) Serious systemic disease may first manifest itself in the conjunctiva, and indicates careful study rather than purely local treatment.

A) An ulcerative, granulomatous conjunctivitis associated with preauricular adenopathy (Parinaud's syndrome) may be caused by:

Disease	Diagnostic Procedure
1) Lues	Serology; dark-field microscope
2) Tuberculosis	Smear; culture; guinea-pig inoculation
3) Lymphopathia venereum	Frei test
4) Tularemia	Agglutination test
5) Leptothricosis	Histologic examination of nodules

B) Exceptionally severe conjunctivitis may be due to gonococcal or diphtheritic infection, and requires appropriate systemic therapy.

C) Thyrotrophic disorders often produce considerable conjunctival hyperemia and edema, usually associated with exophthalmos. Orbital cellulitis presents a somewhat similar picture, with the added features of infection.

D) Trichinosis may first manifest itself by conjunctival redness and edema, associated with muscular soreness (including extraocular muscles).

CONJUNCTIVITIS WITH SERIOUS OCULAR DISEASES

(6) Of great importance is the differentiation of the serious causes of an acute, red eye, e. g., acute iritis, acute glaucoma, scleritis, and keratitis. A misdiagnosis of simple conjunctivitis should not be made in the presence of a detectable amount of corneal opacity, iris inflammation, pupillary inequality, elevated tension or visual impairment. The dusky red engorgement of

deeper vessels, particularly those about the limbus, indicates serious intraocular disease. Prompt, skilled treatment is vital, since delay caused by a misdiagnosis of simple conjunctivitis may cost the patient his vision.

TRAUMATIC CONJUNCTIVITIS

(7) Foreign material is the commonest cause of traumatic conjunctivitis. Acids, alkalis, and toxic chemicals should be irrigated out immediately. Plain water or normal saline is preferable to neutralizing solutions, which are not as readily available and may be excessively strong. Irrigation should be continued for at least 20 minutes and is better tolerated after the use of a topical anesthetic such as 0.5 per cent pontocaine®. Particulate matter such as lime (a common foreign body in plasterers) must be meticulously removed to prevent scarring. Prophylactic antibiotics are indicated every 1 to 2 hours until the corneal epithelium has completely healed as determined by absence of fluorescein staining.

Small conjunctival lacerations heal spontaneously; larger ones may be sutured with running 6-0 mild chromic gut OR silk under topical 0.5 per cent pontocaine® anesthesia. It is of paramount importance to rule out associated lacerations of the globe. Diminished vision, intraocular hemorrhage, or softness of the eye associated with a conjunctival laceration probably indicates intraocular injury. Careful shielding of the injured eye and emergency referral to an ophthalmologist is required.

Even apparently minor contusions may produce traumatic iritis, traumatic cataract, intraocular hemorrhage, secondary glaucoma, retinal detachment or muscular damage. Fundus examinations through a dilated pupil must always be done and the patient should be followed carefully until he is completely asymptomatic. Cold moist compresses for 20 minutes at a time reduce edema and discomfort. Boric acid or other medications need never be used in hot or cold eye compresses.

Subconjunctival hemorrhage, whether spontaneous or post-traumatic, subsides spontaneously without residual in about two weeks and is essentially uninfluenced by therapy.

DIAGNOSIS

Certain features of a conjunctivitis are helpful in etiologic differentiation.

(1) Mucopurulent discharge, involvement of the hair follicles and glands of the lid margins, and superficial hyperemia more marked in the cul-de-sac than about the limbus indicate a bacterial etiology.

(2) Pseudomembranes may be caused by beta hemolytic streptococci and by diphtheria, but also by erythema multiforme, vernal conjunctivitis,

epidemic keratoconjunctivitis (virus) and even by irradiation by x-ray.

(3) Preauricular lymphadenopathy is caused by viruses and granuloma-producing bacteria (ulcerative, nodular type of conjunctivitis), but rarely occurs in ordinary bacterial conjunctivitis.

(4) Allergic conjunctivitis may have a bluish-grey "milky" appearance, often with "cobblestone" flattened papillae in cul-de-sacs. Phlyctenules (small, raised greyish-pink nodules near the limbus) usually denote allergy to tuberculo-protein. Marginal corneal vascularization is often associated with dermatologic conditions such as rosacea, which are controlled with cortisone.

(5) Follicles (small lymphatic nodules) are fairly characteristic of virus infections.

(6) Scarring indicates burns or other trauma, or a severe type of conjunctivitis such as trachoma or pemphigus.

(7) Corneal lesions occur with trachoma, rosacea, phlyctenule. Although minor corneal changes occur with simple conjunctivitis, (e. g. staphylococcal), the physician should regard with suspicion any conjunctivitis associated with corneal changes.

(8) Limbal flush means intraocular disease rather than conjunctivitis. Do not misdiagnose iritis, scleritis, or keratitis as conjunctivitis.

SUMMARY

(1) Methods of therapy of various types of conjunctivitis are described.

(2) Points of diagnostic importance in determination of the etiology of conjunctivitis are briefly outlined.

Justifiable Use of Corticosteroids In Diseases of Hypersensitivity

The use of corticosteroid therapy, it would seem, is not only justifiable but often desirable in diseases with reactions of hypersensitivity that are usually self-limited, such as severe drug eruptions, acute angioneurotic edema, erythema multiforme or dermatitis venenata. If the causative factor has been removed (drug discontinued, irritating plant or chemical discarded), quick relief from discomfort can usually be attained by corticosteroid therapy in sufficient dosages.

If the eruption is severe, cortisone (or comparable amounts of corticotropin or hydrocortisone) given on a schedule of 300 mg. in divided dosages for 24 hours followed by 200 mg. for a day or two, and then decreasing by 25 or 50 mg. each day, usually effects gratifying relief to the patient. And the entire treatment is complete within a week or two so that risks from it are lessened considerably.—Herbert Rattner, M. D., Chicago: *California Medicine*, 83:331, November, 1955.

Franklin County Pelvic Cancer Delay Committee Report

By JOHN H. HOLZAEFFEL, M. D.
Columbus, Ohio, Chairman

The Franklin County Pelvic Cancer Delay Committee met on the third Wednesday of October at 12 o'clock noon. Two cases were presented.

Case 1: The patient, a 53 year old white female, gravida V, Para V, with uneventful menopause the past 10 years, two months prior to hospital admission noticed onset of vaginal bleeding. Patient reported to family physician and was told that the mouth of the womb was rubbing against the wall of the vagina, thus causing the bleeding. She was instructed to use douches. The bleeding continued and a friend of the patient referred her to a second physician who admitted her to the hospital for a biopsy of the cervix. Biopsy reported a poorly differentiated squamous cell carcinoma of the cervix, Clinical Stage I.

Comment: *Dr. W. E. Copeland:* This represents a two month delay on the part of the physician.

Dr. Holzaepfel: It would appear that the patient's friend saved her from increased delay loss by referring her for consultation with another physician.

Dr. W. E. Crisp: All too frequently we find that the lay person seems to be the one who causes less delay than the physician.

Dr. H. E. Ezell: This case also shows the advantage of periodic pelvic examinations. Had this been carried out this lesion might have been found earlier.

Dr. Holzaepfel: At the meeting of the Central Association of Obstetricians and Gynecologists, Dr. Frank McPhail pointed out he had found 23 carcinoma in situ cases by doing papanicolaou smears at the time of periodic examination.

Case 2: This patient had a subtotal hysterectomy in 1928. She noticed occurrence of vaginal bleeding in March, 1955, and procrastinated for two months before seeking medical consultation. The advice she received from this was to take douches as treatment for the vaginal bleeding. She continued this therapy for two months and, because of dissatisfaction, saw another physician at which time a cervical biopsy revealed squamous cell carcinoma of the cervical stump.

Comment: This represents first, a story of patient delay of two months and secondly, inconceivable physician delay of another two months and seems, as in Case 1, that it was more the advice of a friend plus personal dissatisfaction (douches) that returned this patient to more adequate care. Certainly the lesson to be remembered is that vaginal spotting posthysterectomy and postmenopausal makes pelvic examinations imperative and also makes imperative accurate tissue diagnosis. It is conceivable that this patient could have gone for a long period of time with a rather poor degree of medical care without her own initiative and the advice of friends, which is certainly no compliment to the medical profession.

Diseases of the Nervous System

A Pediatric Review

EDWARD C. MATTHEWS, M. D.

HYDROCEPHALUS

ATTEMPTS at correction of gross anatomic defects involving the central nervous system are frequently associated with an unfavorable outcome either in the form of physical and/or mental handicaps in the patient. Such was the case, until quite recently, in the treatment of hydrocephalus. However, in the past 10 years, there have been marked improvements in the surgical management of hydrocephalus, and accordingly it has become the obligation of the pediatrician or family physician following a child through infancy and childhood to detect developing hydrocephalus and to refer the child to the neurosurgeon early when optimal treatment may be instituted.

Matson¹ has recently reviewed the treatment of the various forms of hydrocephalus. On the basis of clinical evaluation coupled with specialized diagnostic procedures, including skull x-rays, subdural, ventricular, and spinal taps, ventriculograms, and studies of the movement of tracer dyes in the cerebrospinal fluid, a patient may be classified into one of three groups and therapy carried out accordingly.

(1) If a patient shows evidence of progressive hydrocephalus without evidence of irreversible central nervous system damage he is a candidate for surgery.

(2) If gross central nervous system damage is present which would be irreversible even if the obstruction to the absorption of spinal fluid were corrected, the patient is considered unsuitable for surgery.

(3) If hydrocephalus is present but arrested, the patient may be followed regularly to assure that there is no further progression.

Since hydrocephalus is the result of obstruction to the flow and normal absorption of spinal fluid, treatment is directed toward establishing either normal flow or toward bypassing the obstruction and directing the cerebrospinal fluid to an area where absorption or excretion may take place. Only rarely is the obstructing lesion amenable to surgical removal. Usually some type of shunt procedure is necessary to bypass the obstruction.

In obstructive hydrocephalus, a shunt may be established between a lateral ventricle and the cisterna magna, between the third ventricle and the basilar cisterna, or between a lateral ventricle and a distant point of absorption such as

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the pleural space, the peritoneal cavity, or the ureter. In communicating hydrocephalus, similar shunting procedures are carried out except that, because there is free communication between the ventricles of the brain and the subarachnoid space, the cerebrospinal fluid may be directed from any point in the subarachnoid space to a suitable absorbing or excreting area.

In the hands of most neurosurgeons the most satisfactory procedure has been the shunting of cerebrospinal fluid through a small plastic tube from the lumbar subarachnoid space to a ureter. This procedure allows excretion of the spinal fluid in the urine but necessitates a nephrectomy on the affected side. Of 65 patients treated by this procedure, Matson¹ reports 36 to be in excellent health and to exhibit normal or only slightly retarded development.

While the surgical treatment of hydrocephalus still leaves much to be desired, sufficient progress has been made to indicate that any child with hydrocephalus deserves at least a neurosurgical evaluation.

CEREBRAL PALSY

Prevention of disease obviously assumes its greatest importance in those illnesses in which therapy is least satisfactory. In the case of cerebral palsy, one is faced with a discouraging statistic that almost 50 per cent of the patients with this disease are so severely handicapped, either mentally or physically, that little or no effective therapy can be offered them. This unfavorable statistic gains even more significance when it is realized that in the United States, there are approximately 11,000 infants born each year who will later develop cerebral palsy. It is therefore self-evident that prevention of cerebral palsy is of primary importance. Prevention however, depends upon a knowledge of cause, and, in the case of cerebral palsy, the cause is often not clearly defined.

According to the classification of the etiology of cerebral palsy proposed by The American Academy of Cerebral Palsy, 30 per cent of all cases are due to unknown cause, less than 10 per cent to postnatal factors, and a small per-

Submitted October 19, 1955.

centage due to heredity. The remaining 60 per cent of cases are attributed to unfavorable environmental factors affecting the fetus in the prenatal and natal periods. It is apparent then that the greatest number of cases of cerebral palsy are obstetrical in origin. This does not imply, however, that they are iatrogenic in origin since mechanical trauma at the time of delivery is considered responsible for only a very small per cent of cases of this disease.

Eastman and DeLeon² have recently presented a study of the relationship of unfavorable obstetrical factors to the etiology of cerebral palsy. In a review of the records of pregnancy and delivery of 96 patients with cerebral palsy, they found that in 78 of the patients the pregnancy and/or labor was attended by some complication and usually there were multiple complications. Complications considered included such things as prematurity, sepsis, either intrapartum or in the immediate neonatal period, bleeding during pregnancy and mechanical trauma.

Because multiple complications were usually present in each case of cerebral palsy, it was not possible to assign any one cause as being of predominant importance. It can, however, be clearly shown that cerebral palsy has a much higher incidence in prematures, but to say that prematurity causes cerebral palsy is usually not justified, since it is probable that in most cases the factor or factors causing the premature labor were in themselves responsible for the cerebral palsy.

In an effort to evaluate more thoroughly the obstetrical factors responsible for the development of cerebral palsy, The American Academy of Cerebral Palsy and The American Academy of Obstetrics and Gynecology are carrying out a detailed joint study of the histories of the pregnancy and labor from which patients with cerebral palsy resulted. Such a study should be highly rewarding in focusing attention on etiologic factors of cerebral palsy.

LEAD POISONING

Death due to accidental poisoning in young children has justifiably been the focus of much attention in recent years. Bain³ in 1954 reported the remarkably high incidence of 3.6 deaths per 100,000 population in the period 1940 to 1949 due to accidental poisoning. She pointed out that two-thirds of the deaths from accidental poisoning could be avoided if aspirin, the barbiturates, kerosene, lye, lead and arsenic were not available to small children. Only by vigorous publicizing of the potential hazards surrounding all children in their early years of life, will the incidence of accidental deaths be reduced, and it is gratifying to see the awareness in parents of these hazards where such publicizing has been carried out.

Lead poisoning carries a double threat to the patient. Not only is the acute episode associated with a high mortality, but, even when treatment

is successful in preserving life, the patient may be left with severe residual brain damage. While it is true that early childhood is associated with a tendency to put "everything in the mouth," certain children seem to have a predilection to ingest lead-containing substances. Why this is true is problematical. Anemia, in itself, may be a stimulus for pica. On the other hand, studies have shown that children with pica and resultant lead poisoning often come from unfavorable home situations where the child's emotional needs are not gratified.

Chisolm⁴ has reported on the environmental factors in childhood lead poisoning. In a review of 89 patients with acute lead encephalopathy, he noted that the usual duration of exposure to lead was three to five months or greater, and that the principal precipitating factor of the acute encephalopathy was the advent of summer. He noted a significant association between the occurrence of severe permanent central nervous system damage and re-exposure to lead following recovery from an episode of encephalopathy.

Needless to say in the management of a case of lead poisoning, the physician's obligation does not end when the blood level is brought down to harmless values. His obligation is a continuing one to assure that re-exposure to lead is avoided.

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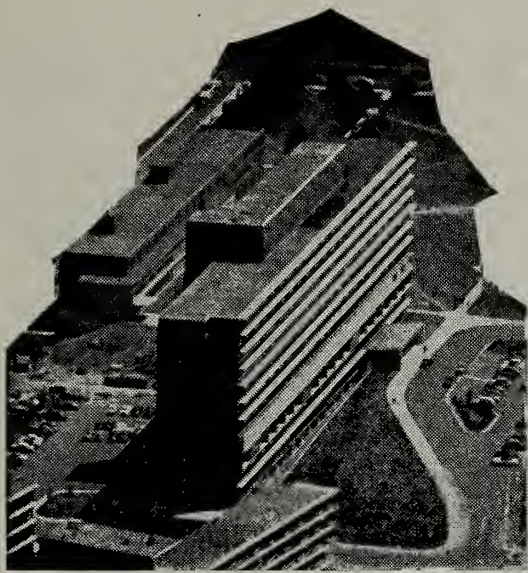
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Observations on Use of Histamine In Medical Practice

Our observations would tend to confirm those of Horton, Prince, Jonez, and others that histamine has considerable, and perhaps as yet unexplored, value as a therapeutic agent. It should not be used without great care, but thus far seems to have been free of any untoward effects.

As Horton said, "In order to rationalize the therapeutic use of histamine in such a wide variety of clinical entities, it is necessary to appreciate fully the known pharmacologic and physiologic effects of this agent in human beings. No other drug has such a wide variety of actions as those possessed by histamine. There is hardly a tissue organ in the human body which will not respond in some way to this powerful agent.

"The response to histamine is often dramatic. Its participation in normal and disturbed physiologic processes is of far greater significance than many physicians realize."—Clarence Bernstein, M. D., and Solomon D. Klotz, M. D., Orlando, Fla.: *J. Florida M. A.*, 42:470, December, 1955.



A Case Record

From The University Hospital,
Columbus, Ohio

Edited Under the Auspices of the Ohio Society of Pathologists

John B. Hazard, M. D., President

Presented by E. T. Boles, M. D., and Emmerich von Haam, M. D.

Edited by Dr. von Haam

PRESENTATION OF CASE

A WHITE male, aged 48 years, was admitted to the University Hospital because of pain, vomiting, melena, weight loss and icterus of several weeks' duration. He had vomited a large quantity of bright red blood several hours before admission and had had frequent tarry stools for the past 3 weeks. He stated that 8 years ago he had undergone a gastroenterostomy at another hospital because of duodenal ulcer.

Two years ago he had hemorrhoids removed and at that time a lesion of his nose was discovered to be a squamous cell carcinoma. Six months ago he had a radical excision of his nose because of the spreading malignant tumor which did not yield to x-ray therapy.

He had had complete relief of his ulcer symptoms until 2 weeks following the operation on his face, at which time he again developed postprandial pains and an active duodenal ulcer could be demonstrated on x-ray study. The pain was relieved by tube feeding, soda and antacids. The patient failed to observe adequate diet and had taken frequent alcoholic beverages until recurrence of severe right upper abdominal pain 3 weeks ago, which continued until the time of his final admission.

PHYSICAL EXAMINATION

The patient appeared poorly nourished, jaundiced and acutely and chronically ill, complaining of cramping pains in the epigastrium. His blood pressure was 115/90, his temperature 101.5°F., his pulse 94 and his respirations 20 per minute. The examination of the head revealed surgical absence of the nose. The wound margins appeared ulcerated but revealed no gross evidence of recurrent carcinoma. The sclerae were icteric.

Examination of the chest revealed coarse moist inspiratory rales in the right base which cleared

after coughing. The heart was not enlarged to percussion; there were no murmurs or thrills. The abdomen was not distended. The bowel sounds were diminished, there was diffuse tenderness over the epigastrium, and there was some abdominal muscular rigidity. The liver was percussed 4 fingerbreadths below the costal margin.

LABORATORY DATA

On admission his white blood cell count was 26,350 with 91 per cent neutrophils and 9 per cent lymphocytes; the red blood cell count was 2.41 million and the hemoglobin 7 Gm. The hematocrit value was 30.5 per cent. Examination of the urine revealed 10 mg. of protein, some white blood cells and 4 plus bacteria. The prothrombin time was 60 per cent. The total serum proteins were 6.2 per cent with 3.2 per cent albumin and 3 per cent globulin. The blood serology was negative for syphilis. His blood amylase was 232 units. His direct van den Bergh reaction was 2.6 mg., his indirect 3.6 mg., the values increased in a few days to 8.4 mg. direct and 14 mg. indirect. The icterus index was 50. During his hospital stay his blood urea nitrogen rose from 17 mg. to 25 mg., and the serum amylase dropped to 99 units. All stool examinations were guaiac-positive.

ROENTGENOGRAPHIC EXAMINATION

An emergency series of his upper gastrointestinal tract showed no evidence of esophageal varices or other structural abnormalities. The barium flowed readily into the stomach and passed through the gastrojejunostomy. No mucosal abnormalities were detected in the stomach. Only a very small amount of barium passed beyond the point of the anastomosis into the pylorus and no barium was seen to enter the duodenum.

The following morning repeat examination showed a large crater-like defect in the deformed

Submitted July 7, 1955.

and contracted duodenal bulb. There was also a questionable ulcer crater at the site of anastomosis. The cholangiogram made a few days after operation revealed a filling defect at the distal portion of the common duct. A repeat cholangiogram showed the cystic and common ducts to be patent and dye was seen in the duodenum. The hepatic ducts could not be visualized.

HOSPITAL COURSE

During the first 3 days the patient received 23 pints of whole blood in an attempt to keep his blood at acceptable level for surgery. On the fifth hospital day he was taken to surgery because of recurrent gastrointestinal hemorrhage. The gallbladder was found to be greatly distended and thick-walled. It was adherent to the omentum and to the transverse colon and contained deep brownish-green material. The duodenum was transected, the stomach opened, and approximately 3000 cc. of old blood were removed from the stomach. An acute ulcer in the prepyloric region was demonstrated.

A hemigastrectomy and a gastrojejunostomy were performed and the duodenal stump was sutured. A mushroom catheter was then inserted into the gallbladder and let out through a stab wound in the abdominal wall. After the operation the bleeding ceased but he continued in poor condition. His jaundice persisted and he had an icterus index of 70 and alkaline phosphatase of 13.3 units. His serum potassium dropped to 2.8 mEq. and the patient was treated with potassium chloride. In addition his temperature continued to spike.

In the following days the patient began to drain large quantities of thick yellow fluid from the drain site, and injection of the draining sinus by diodrast® revealed contrast material within the peritoneal cavity surrounding the sacrum and transverse colon. A continuous suction was applied to this tract and tube feedings into the gastrectomy loop were instituted.

The patient was given whole blood and large amounts of serum albumin and he subsequently improved. The stools remained positive for occult blood and negative for bile. At this time the icterus index was 100 and the van den Bergh reaction was 12 mg. direct and 15.6 mg. indirect. The thymol turbidity test was 50 units. The febrile course persisted with daily temperature spikes to 101 and 102°F. The serum potassium remained low. The patient became even more deeply jaundiced clinically. The blood platelets dropped to 54,000 and later to 34,900.

In the sixth week of his hospitalization he bled approximately 500 cc. of fresh clotted blood from his old cholecystostomy site and was treated with massive whole blood transfusions. He also had two large bloody stools containing bright red clots. The patient was treated with cortisone since it was thought that the repeated transfu-

sions had caused the development of specific platelet antibodies resulting in destruction of his platelets.

For the next 5 days the patient continued to bleed by mouth, through his cholecystostomy wound and by rectum, and also through a small area in the anterior abdominal wound. He required 29 pints of whole blood to maintain even a reasonable blood level. He finally developed signs of a pleural effusion, deteriorated rapidly, and expired 43 days after his last admission.

CLINICAL DISCUSSION

DR. E. T. BOLES: This is a very interesting case. The patient's first three admissions I think we can dispose of rather briefly. He came in and had his hemorrhoids taken care of and then the doctors noticed that he apparently had something wrong with his nose and subjected him to radiotherapy, surgery and again to radiotherapy, taking off more and more of the poor fellow's nose until apparently he had none left. I assume that all this was due to carcinoma and I rather doubt that even at the time of his death this carcinoma was fully controlled. I am quite convinced, however, that this lesion of his nose had nothing to do with his death.

On his fourth admission, however, he was admitted with symptoms of entirely different nature. From these symptoms we can rightly assume that the patient was admitted with a quite significant upper gastrointestinal hemorrhage and the physical findings and laboratory data seem to bear out this opinion. He was quite anemic and showed a markedly elevated leukocyte count which was probably due to his hemorrhage. Since the patient had a history of a gastroenterostomy for duodenal ulcer some 7 years prior to admission, I assume that his physicians felt that he was probably bleeding from either his chronic duodenal ulcer or perhaps from an ulcer at the anastomotic site—a gastrojejunal ulcer. His second x-ray series did show that he had a chronic ulcer in the duodenum.

In the next 4 days the patient got a lot of blood and I presume that surgery was delayed because of the complicating factor of the patient's jaundice. There is no reasonable explanation why this person should be jaundiced on the basis of an ulcer unless one assumes that the scarring and fibrosis around the duodenal ulcer was enough to distort and obstruct the common bile duct. This certainly is very unusual and I know of only one such case.

At any rate, finally the patient was taken to the operating room and the most remarkable finding it seems to me was his gallbladder. From the description it sounds like an acute gallbladder with brownish-green and foul-smelling contents. There is no mention of stones, which I think is a significant observation. However, the acute cholecystitis obviously was not respon-

sible for the patient's bleeding and the surgeon proceeded to do a subtotal gastrectomy and vagotomy. At that time a chronic duodenal ulcer was discovered and in addition a small acute ulcer was found in the antrum of the stomach.

The surgeon states in his operative notes that he was afraid even at this early date that his surgery perhaps might not have corrected the situation entirely since he was skeptical that either of these lesions accounted for the patient's bleeding. Nonetheless, they were certainly present and we know that in cases of upper gastrointestinal hemorrhage three-fourths of the cases are due to hemorrhage from a peptic ulcer either in the duodenum or stomach. In addition to this, because of the inflammation and the distention and the foul-smelling contents of the gallbladder a cholecystostomy was performed, the contents were evidently aspirated and the gallbladder drained.

I think the most significant fact in the postoperative history is that surgery did not help this man, and we must assume from this that the duodenal ulcer and the ulcer of the stomach had nothing or at least very little to do with this patient's gastrointestinal hemorrhage.

COMPLICATIONS

From then on the patient went through a number of complications. First, his jaundice did not improve—in fact, got worse. The exact type of jaundice never was fully ascertained but in all probability it was an obstructive type of jaundice and seemed to increase slowly until the time of the patient's death. In order to determine the status of the biliary tree a couple of cholangiograms were made. The first showed no emptying of the common duct into the duodenum, whereas a few days later it emptied promptly although there was some dilatation. Another observation which I also think is significant is that the hepatic ducts were not visualized. The patient also continued to bleed. Later his bleeding slowed down but did not apparently stop completely.

On the sixteenth postoperative day the patient manifested obvious signs of a duodenal fistula. In other words, the closure of the duodenum had broken down and leaked and duodenal contents poured out from the duodenum and escaped through the drainage wound which had been established in the abdomen. This drainage was a very fortunate procedure since otherwise all of the duodenal contents would undoubtedly have spilled into the peritoneal cavity and might well have caused his death. This is a very serious complication in any type of gastrectomy where the duodenal stump is closed rather than anastomosed to the gastric remnant and it incurs a very high mortality.

In this particular situation, however, the

duodenal blowout did not appear to be fatal and in due time the amount of drainage from the duodenal fistula progressively decreased. It was possible to keep the patient in reasonable electrolyte balance though on two occasions a low serum potassium was noted and I am sure corrected immediately.

However, three weeks postoperatively small amounts of bright red blood were occasionally noted in the duodenal fistula. Four weeks postoperatively the patient had to be given some blood because his hemoglobin had the disconcerting habit of falling and his stools remained constantly guaiac-positive. Later on it was noted that the patient's platelet count was quite low and the hematologists were quickly called in consultation but apparently could find no reason at least from the standpoint of their study to account for his low platelet count. I personally feel that his low platelet count, while undoubtedly a valid observation, was of no particular significance in this man's disease.

BLEEDING—6th WEEK

In the sixth postoperative week he began again to bleed massively and it was noted that one pint of blood escaped from his old cholecystostomy site. It was also noted that in addition to the bleeding from his cholecystostomy, blood was coming from his rectum and he apparently did not vomit blood. The patient was now treated with cortisone because it was felt that perhaps some immunologic condition in his blood had developed to account for the lowered platelets. Terminally the patient seemed definitely to bleed from all orifices; he bled from his mouth, his rectum, his old cholecystostomy site, and from a small area in his anterior abdominal wound. In other words, he was really bleeding again just about the way he was the first few days he was in the hospital.

The most significant fact I gained from reading the patient's hospital course is that the patient was bleeding from a spot which was not discovered at the time of surgery and that the operation was not effective in controlling the bleeding or in preventing subsequent bleeding. Thus we are forced to look for some other cause for his massive upper gastrointestinal hemorrhage. Since our patient did not have a bleeding ulcer of the stomach or duodenum, nor gastritis, nor, according to the radiologist's report, esophageal varices or liver cirrhosis, the cause of his hemorrhage must be more rare and unusual.

In the surgical literature of the last four or five years case reports have been published which seem to fit in perfectly with our case under discussion. The most important clue is, first, that the patient did have upper gastrointestinal bleeding but it was not coming from his stomach and apparently was not coming from the first portion of his duodenum or from his esophagus, so that it must have been coming

from the lower portion of his duodenum or jejunum or one of the closely accessory ducts.

Another fact is the acute cholecystitis which this patient had and the fact that the gallbladder was filled with a very unusual type of material. Foul-smelling dark greenish-brown material is not the type of thing that we ordinarily aspirate from a gallbladder unless the gallbladder is frankly gangrenous, and it is quite obvious that this gallbladder was not gangrenous since only a cholecystostomy was performed. I think that the gallbladder was just full of old decaying blood.

Furthermore, the patient had no obvious cause for obstructive jaundice as far as his terminal bile ducts are concerned, yet one cholangiogram showed obstruction to the terminal bile ducts while a second one showed no such obstruction. So we are justified in thinking that perhaps the common duct was from time to time filled with blood clots. This would account for the patient's slightly vascillating jaundice and the fact that his obstruction was never complete, and that intermittently bile got into his stools.

ANEURYSM

The diagnosis that I am thinking about in our case is that of an aneurysm of the hepatic artery, which I admit seems a pretty bizarre diagnosis. Somewhat less than 100 such cases have been reported in the medical literature up to this time. Apparently 11 of these 100 cases were diagnosed before the patient's death and an operation performed on the patient in an attempt to do something about it. Most of these cases were diagnosed at laparotomy.

The usual clinical picture of such patients is pain, usually in the epigastrium or right upper quadrant, upper gastrointestinal bleeding of the usually massive type, and finally jaundice. Obviously such an aneurysm could be located either in the hepatic artery proximal to the liver or in one of the branches of the hepatic artery within the liver. Should it occur outside the liver it would be theoretically possible to do something about it surgically.

In the first place one could see it and know that it was there, and in the second place it might well be possible, as it has been done on four occasions, to either ligate the hepatic artery proximal to the aneurysm or perhaps to open the aneurysm, if it were a false aneurysm, and sew up the hole, as was done in one of the reported cases. In another case wire was placed into the aneurysmal sac in an effort to coagulate the blood and obliterate the aneurysmal sac by blood thrombi. In two other instances the hepatic artery was ligated proximal to the aneurysm and the patient survived this procedure and had no further bleeding. This was also done in several other cases but the patients expired presumably from hepatic failure.

However, we know that either the right or

left hepatic artery can be safely ligated in most instances if the patient is protected for a period of time following this procedure by massive doses of antibiotics; and the right hepatic artery has been ligated accidentally during the performance of gallbladder surgery. Certainly this diagnosis fits very beautifully with the symptoms of this particular case. Since the patient was operated upon and no such aneurysm was observed, the chances are that it was either right in the hilum of the liver or perhaps even a little further distal in the liver parenchyma. Of course under such a circumstance it would be technically impossible to either diagnose it or do anything about it except to tie off the artery proximal to it.

CLINICAL DIAGNOSIS

1. Aneurysm of hepatic artery with massive gastrointestinal hemorrhage.
2. Postoperative duodenal fistula.
3. Carcinoma of the nose.

PATHOLOGICAL DIAGNOSIS

1. Arteriovenous aneurysm of hepatic artery and portal vein radicles.
2. Massive gastrointestinal hemorrhage.
3. Purulent pylephlebitis with hepatic abscess formation.
4. Perforation of duodenal stump.
5. Generalized peritonitis with subdiaphragmatic abscess.
6. Empyema of right pleural cavity.
7. Carcinoma of the nasopharynx.
8. Obstructive jaundice.

PATHOLOGICAL DISCUSSION

DR. E. VON HAAM: As you see, this seems a complicated case and Dr. Boles made a very, very enticing diagnosis. The autopsy was also quite complicated since so many other procedures had been done previously. The body was emaciated and severely jaundiced. The nose had been removed surgically and the wound edges appeared only partially healed and showed some evidence of progressive neoplasia. Obviously the tumor was not removed radically enough at the first operation and kept on recurring.

The abdominal cavity contained one large abscess involving the perforated duodenal stump and the gallbladder, which contained about 500 cc. of brownish-red fluid, and a subdiaphragmatic abscess bounded by the diaphragm, the spleen and the stomach and partially covered by the gastroenterostomy. There was also a third abscess which was located at the junction of the major bile ducts and extended towards the liver hilum. The three abscesses were separated by fibrous adhesions but seemed to communicate with each other.

The right pleural cavity contained about 1400 cc. of foul-smelling turbid fluid and the pleura was covered with thick fibrinous exudate. The pericardial cavity also contained about 50 cc. of

turbid fluid. The heart was normal in size and showed only minimal sclerosis of the coronary arteries. The right lung was partially compressed and airless and showed a hypocreptant lower lobe which probably was partially consolidated. The spleen was enlarged but firm.

The liver was enlarged and covered partially with fibrinous exudate from the previously described intra-abdominal abscesses. It was slightly nodular, yellowish-green and showed numerous small abscess cavities filled with greenish pus. There were also scattered areas of yellowish-green necrosis in the parenchyma.

The gallbladder was thickened and shrunken and showed a functioning cholecystostomy and a patent cystic duct. The common duct appeared slightly dilated although no area of obstruction could be found at the ampulla. When we opened it we found a large bulging mass of walnut size protruding into the duct at the place where the hepatic duct meets the cystic duct. The mass was bleeding into the common duct and appeared grossly to be an aneurysm filled with partially clotted blood that had perforated into the common duct.

The stomach had been 60 per cent resected. It showed fresh ulcerations around the gastrojejunostomy. A scar from a previous ulcer could be noted in the duodenum, which showed a large perforation at the closure of the stump. A recent jejuno-ileostomy contained a tube and showed also a small ulcer. The distal portion of the small intestine and the colon were filled with tarry, partially decomposed blood. The kidneys appeared swollen and cholemic. The brain weighed 1350 grams and appeared grossly edematous.

MICROSCOPIC EXAMINATION

Sections through the heart showed focal myocarditis probably septic in nature. Sections through the lung showed a fibrinopurulent pleurisy and pulmonary atelectasis. The microscopic examination of the mass in the region of the liver hilum confirmed our suspicion of an aneurysm. One vessel connected with the aneurysm resembled in structure the hepatic artery, while another appeared less muscular and seemed to continue into a tributary of the portal vein. The sac of the aneurysm was formed by fibrous tissue without smooth muscle fibers. There was no evidence of lues or arteriosclerosis, but the inflammatory reaction present in the wall of the aneurysm suggested a mycotic process of some kind.

Sections through the liver showed acute and subacute cholangitis with obstructive jaundice and liver necrosis with abscess formation. The kidneys showed a mild cholemic nephrosis. Microscopic study of the surgical defect in his face showed many areas of squamous cell carcinoma at the margin of the resection. Sections through the brain showed mild perivascular edema.

In summary then we could confirm Dr. Boles

"bizarre" diagnosis and could demonstrate a perforated arteriovenous aneurysm of the hepatic artery in the hilum as the source of the severe and finally fatal gastrointestinal hemorrhage and of the vascillating obstructive jaundice of this unfortunate patient. The patient undoubtedly died also from the consequences of his septicemia and all types of Gram-negative and Gram-positive organisms could be recovered from his various lesions. He was of course doomed to die eventually from the cancer of his face.

GENERAL DISCUSSION

DR. VON HAAM: Would you care to comment upon this case, Dr. Williams?

DR. ROGER WILLIAMS: While this lesion seems rather rare as a cause of gastrointestinal hemorrhage, it ranks about second or third when you rule out the usual obvious causes such as duodenal ulcer, gastric ulcer and esophageal varices. About one-third of the 89 patients reported in 1952 presented the complete triad of abdominal pain, jaundice and gastrointestinal hemorrhage as this patient. There were actually two members of the staff who made the diagnosis on this patient prior to his death. Most of the hepatic arterial aneurysms have been extrahepatic and in about 80 per cent of the extrahepatic ones the first symptom has been massive hemorrhage into the abdominal cavity. Only about 26 per cent have actually bled into the gastrointestinal tract.

DR. VON HAAM: Are these aneurysms considered congenital, mycotic or arteriosclerotic?

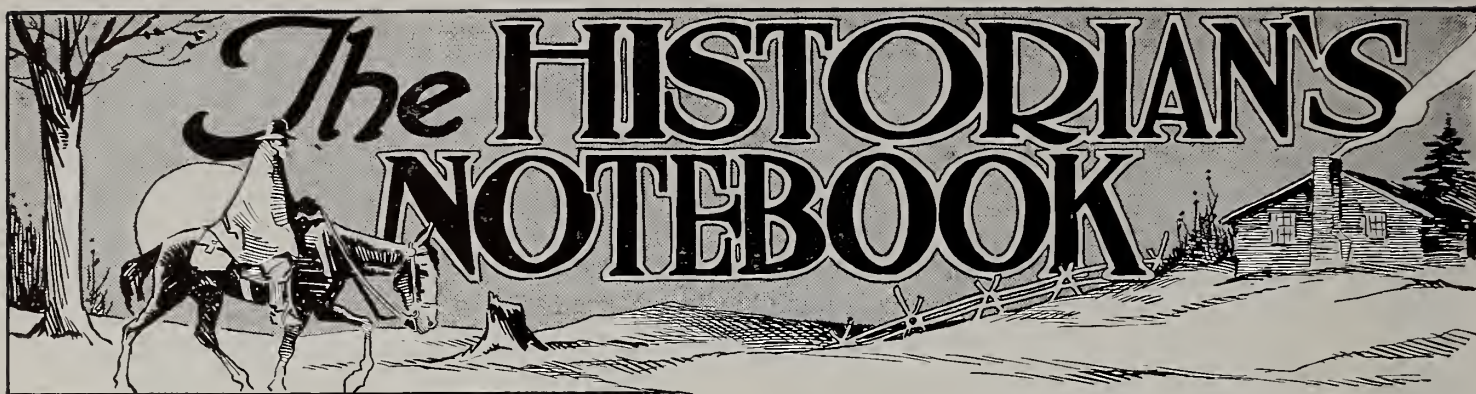
DR. WILLIAMS: The most common cause of them is an infectious arteritis. The second common cause is arteriosclerosis and the third one is trauma. Only one case was reported to be due to syphilis and that remained questionable. I don't think we could have done anything for this man even if we had made the correct diagnosis earlier. The mortality from ligating the hepatic artery depends on where you ligate, but even so the mortality is around 75 per cent. In a man with this much jaundice and liver damage it would have taken a lot of collateral blood supply to have kept the liver functioning.

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Ego Breakdown in the Aged

Our own experience indicates that the elderly person is more concerned about *how* he is to die than *when* or *if*. We are all aware of the effects of chronic pain in the elderly cancer patient. These fears can constitute a major factor in the production of ego breakdown in the elderly.—Ewald W. Busse, M.D., et al., *Durham: North Carolina M. J.*, 16:528, 1955.



"The Dromedary Symptom Complex": The Evolution of an Error

BYRON STINSON, M. D.

MOST medical authors justify the obscurities they write about by pointing out that though such-and-such a syndrome is quite rare it is vitally important to recognize it so as to help the patient prepare himself for the hereafter as expeditiously as possible. This paper is even more difficult to justify than usual; in fact, one reference characterizes the whole hassle as unimportant. The problem, however, has been most interesting to me, and I think the paper is worth reading.

All of us for many years have used the term "dromedary" to describe the recurrent nature of the symptom complex seen in some cases of poliomyelitis. This is a handy and dramatic label, and were it not for the fact that the dromedary camel has but one hump, a good one.

MOUSE TRAP

It all started with Draper, a pioneer student of poliomyelitis, who in 1916 studied the great New York City epidemic. In writing his monograph, *Acute Poliomyelitis*, he fell into this simple trap: "Because of the two definite masses or humps of symptoms, the analogy to the arrangement of the dromedary's back was taken to express the type figuratively. The first series, called the dromedary group, shows clearly two distinct periods of illness with an interval of well-being." (In the same vein, he named the dilatory course shown by some patients as "straggling.")

Later authors, typified by Landon and Smith in 1934, cemented the error as follows: "In a smaller per cent of cases there is initially a systemic disturbance followed shortly by a variable period of time in which the patient is apparently well, only to suffer a recurrence of symptoms and subsequent evidence of central nervous system involvement. This is Draper's 'dromedary' type."

Submitted January 15, 1954.

The Author

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In 1941 Lewin, not to be outdone in flamboyant phraseology, seized Draper's terms "dromedary" and "straggling," and added one of his own: "sledgehammer." This last to indicate the occasional case of poliomyelitis with a sudden overwhelming onset. (Apparently it was this paper that gave the cue to General Headquarters to name the Normandy invasion "Overlord," and the invasion of Africa "Torch.")

Thus, in 1941, we end up with poliomyelitis having three types of onset, and three catching, even poetical, if somewhat inaccurate names:

- (1) Dromedary
- (2) Straggling
- (3) Sledgehammer

Not to be denied at this point are two other deathless terms that I turned up in Lewin: "Pole-to-pole" and "Coast-to-coast." These two can be used as synonyms for "sledgehammer," but only when extensive paralysis is present. Helpful, what!

STILL SMALL VOICE

The first glimmer of light in this zoological darkness came in 1948. Wilson, writing for *Brenneman's Practice of Pediatrics*, comments: "When the initial rise of temperature does occur, the resulting two-humped temperature curve is termed the 'dromedary course,' this expression having been used by someone who thought the two peaks resembled the humps of a camel. It is unfortunate, and also unimportant that the

true dromedary has only one hump. The term still persists however.” (Dr. Wilson meet Dr. Draper.)

In June, 1954, Seifert remarks briefly: “The first phase in the diphasic or misnamed dromedary type, is an indefinite and undiagnosable febrile period.”

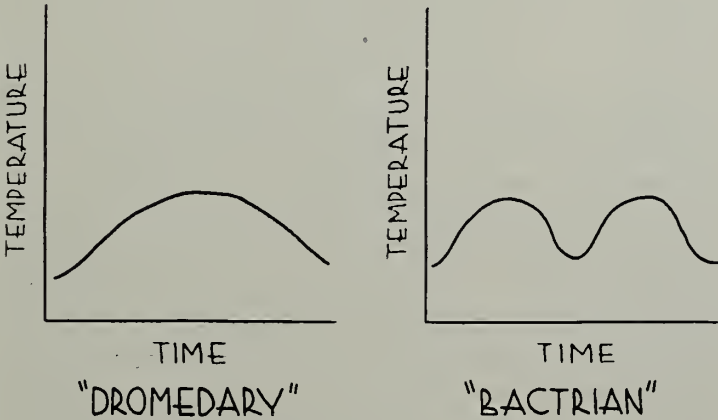
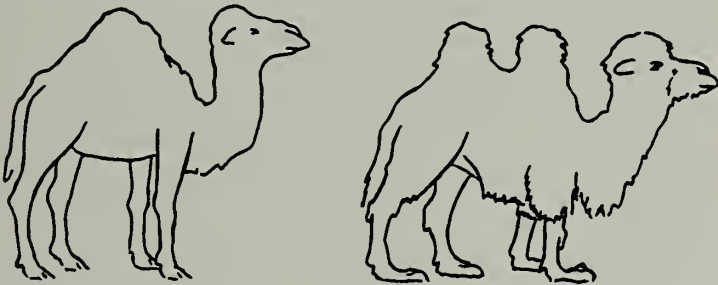
NINE LIVES

That the ‘error persists’ is shown by the quotation from Hoyne in 1951: “The so-called dromedary examples of poliomyelitis consist of an initial illness of two or three days following which there is an apparent recovery. However, after three to seven days there is a secondary rise of temperature, and some form of paralysis makes its appearance.”

Tichy and Baker in 1953 follow the lead of Draper with: “The course may vary and the ‘dromedary’ course, seen more commonly in children, includes a brief period of remission between the prodromata and the onset of the paralytic stage.”

The terms “straggling” and “sledgehammer” never took root, but “dromedary” flourished and continues to do so. This is probably because it is such a valuable point in the differential diagnosis of polio. Certainly this point should always be checked in the history of a summer and autumn febrile illness.

For the purist, Webster’s New International Dictionary and The Encyclopedia Britannica, two unimpeachable authorities, concur with Wilson . . . the dromedary has but one hump. The en-



cyclopedia puts it this way: “‘Camel,’ the name applied to the two species of the genus *Camelus* of the order *Artiodactyla* (g.v.). Of the two species *C. dromedarius*, the Arabian Camel is larger and has only one hump, while the Bactrian Camel, *C. bacteranius*, has two.”

Thus, for 37 years the medical profession has designated a two-humped symptom complex with the name of a one-humped camel. The wound first opened by Wilson has bled but little.

A healthy omen is found in Batson’s paper in 1954. He avoids the “dromedary” trap by calling the complex a “biphasic clinical course” (not to confuse you, but Seifert calls this “diphasic”). We could end up (Heaven forbid!) with the types of onset designated:

- (1) Biphasic, or Diphasic, or (horrors!), Bactrian
- (2) Dilatory
- (3) Overwhelming

As already intimated, with the exception of the biphasic (or diphasic if you prefer) the above series is largely and happily ignored, the disease being labeled for its primary manifestation such as bulbar, abortive, paralytic, and the like. This is a pleasant and business-like trend.

I suggest that the dromedary be allowed to graze into oblivion much like the old soldier who never dies. After all, the dromedary is a one-humped camel.

Acknowledgment: Anne Stinson, B. S. (Illustrator).

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Historic Hildreth Home in Marietta To Remain for the Present

The Hildreth Home in Marietta has been granted a reprieve by the people of Washington County. At the November election, a bond issue to finance remodeling and perhaps razing of this historic landmark to provide for an annex to the Washington County Court House was decisively defeated.

“Dr. Samuel P. Hildreth and the Hildreth Home” was the subject of an article by Richard L. Wenzel, M.D., of the Columbus Health Department, in the December Historian’s Notebook. The author reported this addendum to his article following the election, with the notation that there are at the present time reportedly no funds or immediate plans for alterations or utilization of the building.

The home has been used as a commercial building since 1903. It was purchased by Washington County on November 13, 1954, at a sheriff’s sale.

Proceedings of The Council . . .

Heavy Docket Considered at Meetings Held on December 10 and 11; Committee Reports Approved; Verdict Rendered in Bolinger Case

A REGULAR MEETING of The Council of the Ohio State Medical Association was held on December 10 and 11, 1955, in the Columbus Office. All members of The Council were present. Others in attendance were: Mr. Wayne E. Stichter, Toledo, legal counsel, and Messrs. Nelson, Saville, Page and Moore of the headquarters office staff.

Minutes of the meetings of The Council held on September 17 and 18, 1955, at Granville, Ohio, were approved on motion duly made, seconded and unanimously carried.

MEMBERSHIP STATISTICS

Membership statistics were reported by the Executive Secretary as follows: Total membership in the Ohio State Medical Association as of December 9, 1955, 8,603, including 131 whose dues have been waived because of military service and 222 whose dues have been waived because of retirement due to age or disability, compared to 8,375 as of December 31, 1954. Of the 8,603 Ohio State Medical Association members on December 9, 1955, 7,482 held membership in the AMA, including 127 whose AMA dues were waived because of military service and 425 whose dues were waived under the age and retirement waiver provisions of the AMA. The AMA total compared to 7,317 as of December 31, 1954.

A request from the Belmont County Medical Society for a copy of its charter was approved by The Council, subject to confirmation by the House of Delegates at the 1956 Annual Meeting.

AMA MEETING

Dr. Woodhouse and Mr. Saville presented reports on the recent meeting of the AMA in Boston and referred members of The Council for details to the story which will be published in the January issue of *The Ohio State Medical Journal*. (See page 70.) They both referred particularly to the resolution presented by the Ohio delegates pertaining to the recent survey of Ohio physicians on whether or not physicians should be included in the social security program. The resolution, which was approved by the House of Delegates, recommended that the Board of Trustees of the AMA request all state societies to conduct a similar survey and report their findings to the AMA Board of Trustees.

MEDICAL ASSISTANTS SOCIETY

A communication from the Toledo Academy of Medicine, stating that it had endorsed the Medical Assistants Society of Toledo and Lucas County and had appointed an advisory committee to that

organization, was read. The communication referred to the fact that the medical assistants group is anxious to have a statewide organization established and wants an advisory committee on the state level. The Toledo Academy letter requested The Council of the State Association to give this matter consideration.

There was considerable discussion of this and it was the opinion of The Council that additional information was needed before The Council could take action. It instructed the Executive Secretary to secure additional information from various sources regarding the purposes, objectives and activities of the organization of medical assistants and comments as to whether there is a need for a state organization.

INSURANCE PLAN SHELVED

A report on a poll taken of county medical societies on the matter of whether or not the Ohio State Medical Association should sponsor a group health, accident and disability insurance program for members of the Association, was given lengthy consideration by The Council. Data obtained from other sources also was studied. By official action, The Council expressed the belief that most if not all of the members of the Ohio State Medical Association have an opportunity now to enroll in group health, accident, and disability insurance programs which are being carried on throughout the state on either a county or a district basis. For these reasons, The Council decided that many, also, may secure coverage from plans sponsored by national medical societies. It is neither necessary nor desirable for the Association to enter into such a program at this time.

FINANCES AND BUDGET

The Council then went into executive session for the purpose of discussing and acting on a report from the Committee on Auditing and Appropriations, presented by Dr. Robert S. Martin, chairman. The report of the committee which included the following recommendations was officially approved: (1) The House of Delegates should be asked at the 1956 Annual Meeting in April to increase the annual per capita dues \$5.00, making dues \$25.00, effective January 1, 1957, and a statement should be prepared by The Council enumerating the needs for increased dues, which statement should be published in *The Journal* and distributed to county medical societies and delegates; (2) a new man should be added to the Columbus Office staff as an executive

assistant and field secretary; (3) adjustments should be made in the payrolls of the Association and *The Journal* to bring salaries into line with cost-of-living increases and to provide additional compensation on the basis of merit and length of service.

BUDGET FOR 1956

In adopting the report of the committee, The Council approved the following budget for the calendar year 1956:

The Ohio State Medical Journal	\$ 32,000.00
Executive Secretary, Salary	16,500.00
Executive Secretary, Expense	2,000.00
Stenographic and Clerical Salaries	30,940.00
President, Expense	1,200.00
President-Elect, Expense	500.00
Council, Expense	4,000.00
American Medical Association Delegates	5,000.00
Dept. of Public Relations	37,500.00
Director, Salary	\$14,000.00
Director, Expense	2,000.00
Asst. Director, Salary	9,000.00
Asst. Director, Expense	2,000.00
Exhibits and Newspaper	
Publicity	1,000.00
Literature	3,000.00
Postage	2,000.00
Supplies	500.00
Miscellaneous Activities ..	4,000.00
Committee on Education	250.00
Committee on Public Relations and Economics	600.00
Committee on Scientific Work	750.00
Committee on Auditing and Appropriations	700.00
Committee on Blood Banks	200.00
Committee on Chronic Illness	750.00
Committee on Industrial Health	500.00
Committee on Veterans' Affairs	1,000.00
Military Advisory Committee	3,500.00
Chairman, Salary	3,000.00
Committee, Expense	500.00
Committee on Maternal Health	1,000.00
Miscellaneous Committees	500.00
Committee on Rural Health	3,000.00
Rural Medical Scholarships	2,000.00
Committee on School Health	1,000.00
Annual Meeting	22,000.00
Conference County Society Presidents-Secretaries	1,500.00
Employees Retirement Fund	4,039.90
Insurance and Bonding	3,000.00
Postage	2,000.00
Professional Relations Activities	6,000.00
Rent and Utilities	9,075.00
Stationery and Supplies	3,000.00
Telephone and Telegraph	3,000.00
Legal Expense	5,000.00
Emergency and Equipment Fund	10,000.00
TOTAL	\$214,004.90

DUES FOR MILITARY MEMBERS

The Council then considered provisions of Chapter 2, Section 1, of the By-Laws, as revised by the House of Delegates at the 1955 Annual Meeting. This section gives The Council the right to determine the amount of dues which shall be charged members of the Association on extended active duty in the military service or in the U. S. Public Health Service and members serving as hospital interns or residents.

After extensive discussion, The Council adopted the following policy providing for waiver of State Association dues for members on extended active duty in the military service or in the U. S. Public Health Service:

"1. State Association dues for 1956 shall be waived for members on extended active duty in the military service or U. S. Public Health Service.

"2. State Association dues for 1956 shall be waived for physicians who were members of the Association in 1955 and who enter such services during the calendar year 1956 before the payment of 1956 dues.

"3. A refund of membership dues will not be made if a member enters such services in 1956 after his 1956 dues are received at the Columbus Office of the Association.

"4. The secretary-treasurer of each county medical society shall be requested to cooperate with the Columbus Office in assembling the names of physicians entitled to waiver of dues under the foregoing provisions."

DUES FOR INTERNS, RESIDENTS

By official action, The Council then adopted the following policy relating to dues for interns and residents for the calendar year 1956:

"Annual Ohio State Medical Association dues for a physician serving a hospital internship or residency during the first five years following graduation from medical school (excepting the time spent in military service), who meets the membership eligibility requirements of the Ohio State Medical Association and who is accepted into membership by a component medical society, shall be \$7.50. Such intern or resident member shall be offered a subscription to *The Ohio State Medical Journal* at one-half the regular subscription rate."

The question of a temporary state license for interns and residents was given further consideration. The Executive Secretary was instructed to secure additional information on this question from such sources as the Association of American Medical Colleges, American Medical Association, licensing boards of other states, etc., and to report his findings at a future meeting of The Council.

LABORATORY ADVERTISING

The Executive Secretary asked for instructions as to whether *The Journal* should accept advertising from clinical and diagnostic laboratories. The

matter was discussed thoroughly and reference was made to a resolution on laboratory advertising adopted by the House of Delegates of the AMA at the 1955 meeting at Atlantic City. The resolution stated that advertising by laboratories is, in effect, the solicitation of business and therefore unethical. By official action, The Council instructed the management of *The Journal* not to carry laboratory advertising.

Amendments adopted by the Trumbull County Medical Society to its by-laws at a recent meeting, providing for a class of members known as "associate members," were approved by The Council.

DECISION IN BOLINGER CASE

The Council then considered the appeal of Dr. Charles E. Bolinger, Marysville, from the order of expulsion entered by the Union County Medical Society on December 17, 1954. Fourteen members of The Council, including the President who presided, participated.

By a vote of 13 to 0, with the president serving as chairman and not participating, The Council returned the following decision and order, and instructed the Executive Secretary to notify Dr. Bolinger and his attorneys and the Union County Medical Society and its attorneys of the action taken:

BEFORE THE COUNCIL OF THE OHIO STATE MEDICAL ASSOCIATION

In the Matter of the Appeal of Dr. Charles E. Bolinger from the order of expulsion of the Union County Medical Society	DECISION AND ORDER
--	--------------------------

(Rendered December 11, 1955)

There has been submitted to The Council of the Ohio State Medical Association for determination and decision the appeal of Dr. Charles E. Bolinger from the order of the Union County Medical Society of December 17, 1954, expelling Dr. Bolinger from membership in such Society.

The Council has made a thorough study of the entire Record filed in connection with the appeal, including the voluminous transcript of the testimony, evidence and proceedings before the Union County Medical Society, and has given careful consideration to the briefs and oral arguments of counsel for Dr. Bolinger and counsel for the Society. As a result of such study and consideration, the Council makes the following findings:

(1) The Record filed with The Council does not disclose that there were any errors or irregularities in the proceedings before the Society which prevented Dr. Bolinger from having a fair trial in accordance with the Constitution and By-Laws of the Society and the Constitution and By-Laws of the Ohio State Medical Association.

(2) The Record discloses that the evidence offered in connection with Charges No. 1, No. 2,

No. 4, and No. 7 is sufficient to support and sustain the Society's findings that Dr. Bolinger was guilty of violations of the Constitution and By-Laws of the Society and the Principles of Medical Ethics.

(3) Charges No. 3, No. 5, and No. 6 are not supported by any competent evidence in the Record.

(4) With respect to Charge No. 8, the Record discloses that prior to, and at the time of, Dr. Bolinger's admission to membership in the Union County Medical Society, the Society, through its officers, knew that Dr. Bolinger had practiced medicine in Hamilton, Ohio; consequently, the Society could not have been misled by the alleged failure of Dr. Bolinger to state in his application for membership that he had practiced in Hamilton. Moreover, at the time his application for membership was filed, the Society had no prescribed application form calling for such information, and there is no evidence that Dr. Bolinger then knew that the By-Laws of the Society (of which he was not yet a member) required a disclosure of the places where he had formerly practiced. Charge No. 8 and the evidence offered in support thereof fail to establish any violation as alleged.

(5) The acts recited in Charge No. 9 do not involve or relate to Dr. Bolinger's conduct while a member of the Union County Medical Society; these acts allegedly occurred in 1945-1949, long prior to his admission to the Society. In the opinion of The Council, Charge No. 9 does not constitute a valid charge cognizable and triable by the Society. Charge No. 9 is consequently not sustained.

(6) The proof made of Charges No. 1, No. 2, No. 4, and No. 7 fully justified the bringing of disciplinary action against Dr. Bolinger and the Society's finding that he had violated the Constitution and By-Laws of the Society and the Principles of Medical Ethics. However, the penalty of expulsion from the Union County Medical Society is, in the opinion of The Council, too severe and ought to be modified so as to provide for suspension rather than expulsion.

It is therefore ordered that the finding of the Union County Medical Society that Dr. Charles E. Bolinger was guilty of violations of the Constitution and By-Laws of such Society and of the Principles of Medical Ethics be, and the same hereby is, affirmed. It is further ordered that the Society's order of expulsion of December 17, 1954, be and the same hereby is, reversed and set aside, and that Dr. Bolinger stand suspended from membership in the Union County Medical Society, and from all rights, prerogatives and privileges pertaining thereto, from and after December 17, 1954, to and until January 1, 1960.

Two of the four charges on which Dr. Bolinger was found guilty related to false accusations al-

leged to have been made by him concerning the professional conduct of certain members of the Union County Medical Society. The other two charges sustained were the alleged neglect of a hospital patient by him and the alleged withholding by Dr. Bolinger of required information in his application for surgical privileges at the Union County Memorial Hospital, Marysville.

ANNUAL MEETING

A report on Annual Meeting program arrangements was made by the Executive Secretary, showing that all arrangements were progressing satisfactorily. The question of entertainment on Wednesday evening, April 11, was again considered by The Council. After a lengthy discussion, The Council instructed the Executive Secretary to arrange for a dinner and entertainment similar to banquet programs of recent annual meetings.

COUNTY SOCIETY OFFICERS CONFERENCE

The Council selected the date, Sunday, February 12, for the Annual Conference of County Society Officers and Committee Chairmen. The conference will be held on that day at the Neil House, Columbus. Numerous suggestions for the program were made by members of The Council. The Executive Secretary was given authority to arrange the program in line with the suggestions offered.

COMMITTEE REPORTS

A report from the Committee on Public Relations and Economics, based primarily on a meeting of the committee on October 2, 1955, was presented. After complete discussion, The Council approved the report and actions of the committee. (See page 61 for story on committee's actions.)

The Committee on Maternal Health reported on a meeting held in the Columbus Office on December 4, 1955. Actions and recommendations of the committee were approved by The Council by official action. (See page 60 for story on committee's actions.)

ADVISORY COMMITTEE

Mr. Page reported for the Committee on Rural Health. He asked The Council to consider a request from the committee for the appointment of an advisory committee which could assist the Rural Health Committee in promoting the Ohio State Medical Association rural medical scholarship during 1956. After discussion The Council authorized the appointment of the following to the advisory committee: Mr. W. B. Wood, director, Agricultural Extension Service, Ohio State University, Columbus; Mr. E. W. McMunn, editor, *The Ohio Farmer*, Cleveland; Mr. Byron Frederick, master, Ohio State Grange, Columbus; Mr. R. Bruce Tom, health chairman, Ohio State

Grange, Columbus; Mr. H. D. Heckathorn, president, Ohio Farm Bureau Federation, Forest; Mrs. Litta K. Roberson, director of Women's Activities, Ohio Farm Bureau Federation, Columbus; Mr. H. W. Harshfield, State 4-H Club Leader, Ohio State University, Columbus; Mr. William Zipf, farm editor, *The Columbus Dispatch*, Columbus; Mr. A. W. Short, supervisor, conservation education, Departments of Education and Natural Resources, Columbus; Mr. A. W. Orcutt, rural sociologist, Agricultural Extension Service, Ohio State University, Columbus.

LECTURES TO SENIORS

Mr. Page informed The Council that the scholarship pamphlet would be reprinted. Also, he advised The Council that arrangements had been completed for the lectures on general practice in small communities before the senior class at Ohio State University and the senior class at the University of Cincinnati in the Spring of 1956.

NEW ORGANIZATION NOT NEEDED

Mr. Page also reported on a meeting in Chicago on October 9, which he had attended as official representative of the Ohio State Medical Association. The meeting was called by the Councils on Rural Health and Medical Service of the AMA to discuss whether or not steps should be taken to organize a new national organization for state and local health councils. Mr. Page reported that the sentiment at the conference was overwhelming against a new national organization of this kind and he advised The Council that since the meeting the officials of the AMA Councils had recommended to the Board of Trustees of the AMA "that there is no evident need and no evident majority demand for the organization of State Health Councils." The report by Mr. Page was accepted and approved.

OMI NOMINATING COMMITTEE

By official action, the President was authorized to name a nominating committee, consisting of three members of The Council, to prepare a slate of nominees for the Board of Directors of Ohio Medical Indemnity, Inc., and which slate, after approval by The Council, would be presented at the annual stockholders' meeting of OMI in April, 1956.

DEFINITION OF "CLINIC"

The Executive Secretary reported that he had received some information from various sources on what might be considered a "clinic." The information obtained revealed that there is no uniform definition or even understanding pertaining to minimum requirements for clinics. The Council was advised that the AMA is at the present time, through the Judicial Council and the Council on Medical Service, giving consideration to this question. It was the opinion of The Council, therefore, that no specific definition

The Council Poses Following Meetings in Columbus



Members of The Council are shown above as they posed following the meetings Saturday evening and Sunday, December 10 and 11. Seated left to right: Drs. Edwin H. Artman, Tenth District; Charles L. Hudson, President; M. D. Prugh, Past-President; George A. Woodhouse, Second District; Mr. Wayne E. Stichter, Legal Counsel; and Dr. Robert E. Hopkins, Seventh District.

Standing, left to right: Mr. George H. Saville, Public Relations Director; Drs. Robert S. Martin, Eighth District; C. L. Pitcher, Ninth District; George W. Petznick, Fifth District; Paul F. Orr, Fourth District; James R. Jarvis, Third District; H. T. Pease, Eleventh District; Mr. Charles S. Nelson, Executive Secretary; Drs. C. T. Atkinson, First District; and C. A. Gustafson, Sixth District.

Not present when this picture was taken was Dr. R. L. Meiling, Treasurer. Also present were Hart Page and Gordon Moore of the Headquarters staff.

could, or should, be adopted by The Council at this time, but that cases arising should be considered and determined individually and each on its own merits.

BY-LAWS OF COUNTY SOCIETIES

On the recommendation of Mr. Stichter and the Executive Secretary, The Council authorized them to begin the drafting of a revised "model" constitution and by-laws for county medical societies. It was pointed out that many of the local documents have not been revised for a considerable number of years and that in other instances many piecemeal revisions have been made by local societies. The Council felt that the revised "model" could take into consideration certain changes made in the By-Laws of the State Association and that the revised document could be offered to the county societies for consideration and action supplanting their present constitution and by-laws.

FEDERAL LEGISLATION

There was a lengthy discussion on certain proposals which will be acted on by the Congress

at its next session starting January 1. Particular attention was called to H. R. 7225, which amends the Social Security Act, including a provision for disability benefits. Action of the House of Delegates of the AMA at the recent Boston meeting called attention to the dangers of H. R. 7225 and asked for an objective, thorough and impartial study of the present Social Security System before the enactment of more social security legislation. On motion duly made, seconded and carried, The Council approved and affirmed the action taken by the AMA House of Delegates on H. R. 7225 and on the question of social security in general.

PHYSICIAN-HOSPITAL RELATIONS

The Council then gave consideration to a statement of policy on "physician-hospital relations," drafted and approved jointly by the Committee on Hospital Relations of the Ohio State Medical Association and the Committee on Professional Relations of the Ohio Hospital Association. It was pointed out that the statement has been approved by the Board of Trustees of the Ohio

Hospital Association and is now before The Council of the Ohio State Medical Association for consideration. After thorough review and discussion, The Council, by official action, approved the statement and instructed the Executive Secretary to give it wide circulation.

MEDICAL EDUCATION FOUNDATION

Mr. Saville reported for Dr. Wm. M. Skipp, Chairman of the Ohio campaign in behalf of the American Medical Education Foundation, a total of \$24,432.50 from 388 contributors as of November 30, 1955. This amount includes \$4,855 from the Woman's Auxiliary to the Ohio State Medical Association; \$2,500 from the Frederick M. Douglass Foundation, Toledo, and \$2,000 from the Mahoning County Medical Foundation, Youngstown. The Ohio AMEF total as of November 30, 1954, was \$19,752.50 from 488 contributors. This was increased to \$25,333.50 from 654 contributors at the close of 1954. During that year 1,995 Ohio physicians gave a total of \$71,172.61 directly to Alumni Funds of their own medical schools.

IOWA DECISION

Reference was made to the recent decision in the district of Polk County, Iowa, which held that certain Iowa hospitals are engaged in the unauthorized practice of medicine because of certain practices involving the pathological and x-ray departments of such hospitals. It was pointed out that the Iowa decision is of particular interest in Ohio because of the present suit pending against the Hopkins Clinic in Cleveland, in which similar questions are involved.

MALPRACTICE STUDY

Mr. Stichter and Mr. Nelson advised The Council that a communication has been prepared on the collection of malpractice data and will be sent to county society presidents shortly after the first of the year, requesting them to have such data collected in their county and advising them as to procedures which should be set up to secure such malpractice data.

PROJECT NOT APPROVED

A letter from Mrs. Carl Ritter, president of the Woman's Auxiliary, asking for an opinion on a project which would involve a poll by the Auxiliary of physicians to secure information about the time and effort a physician contributes to his community, was read and discussed. A voluminous questionnaire which would be used to secure facts and statistics, including financial data, was studied. It was the opinion of The Council, by official action, that such a survey should not be made by the Auxiliary.

Following reports by members of The Council on activities in their districts The Council adjourned to meet at the call of the President.

Attest: CHARLES S. NELSON,
Executive Secretary.

Two Drugs In Short Supply

According to information sent to *The Journal* by the Ohio State Pharmaceutical Association, equanil and miltown may be in very short supply for several weeks in some areas due to a shortage of production facilities for basic ingredients. Physicians are requested to prescribe these drugs only in extreme cases and to caution their patients there may be some delay in getting prescriptions filled.

Dr. Schriver Honored for His Work with Blue Shield

Dr. L. Howard Schriver, Cincinnati, recently was given a testimonial dinner at the Edgewater Beach Hotel, Chicago, in recognition of his nine years of leadership as president of National Blue Shield. The dinner was attended by the entire National Blue Shield Commission and executive staff as well as by the official representatives of the National Blue Cross Commission.

Following the dinner, a testimonial gift was presented to Dr. Schriver by the in-coming president of the Blue Shield Commission, Dr. Norman Welsh, of Boston. In addition, one hundred testimonial letters—from medical and nonmedical persons throughout the United States, Hawaii and Puerto Rico—were mounted in a leather book and given to the retiring president. These letters paid tribute to Dr. Schriver as an outstanding and courageous exponent of voluntary medical care, and expressed gratitude for his tireless efforts in behalf of the Blue Shield Plans the country over.

Dr. Schriver had also served as president of the Ohio Medical Indemnity organization, for nine years, until his resignation in 1954. At that time he was given a testimonial gift in recognition of his efforts in behalf of the Ohio Blue Shield Plan.

On December 5, Dr. Schriver was honored at a meeting of the Public Health Federation of the Community Chest and Council of Social Agencies of Cincinnati, when he was named one of two recipients of the PHF annual award.

The citations praised Dr. Schriver as a leader in maintenance of professional ethics, community health and economics, especially as exemplified by Blue Shield.

Atlanta Assembly

Ohio physicians interested in combining a medical assembly with a February trip southward may find the Atlanta (Ga.) Graduate Medical Assembly to their liking. Dr. Mark S. Dougherty, 15 Peachtree Place, N.W., Atlanta, chairman of the publicity committee, has issued the invitation to Ohio physicians. Physicians are invited to write Dr. Dougherty for details. Dates of the assembly are February 20-22.

ACHR

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Maternal Health . . .

Committee Reports to The Council; Continues Study of Maternity Deaths; Supports Establishment of Educational Program in Analgesia-Anesthesia

FOLLOWING is a resumé of actions taken by the Committee on Maternal Health at a meeting on December 4, 1955, in the Columbus Office. A report on the meeting was presented to The Council at its session on December 11, 1955, and approved by The Council.

The first matter considered by the committee was a report on all districts with respect to the return of the study blanks. Committee members were urged to make every effort to have the blanks returned to the Columbus office at the earliest possible date so that work can be started in evaluation of the reports.

The form now in use was reviewed and a number of changes suggested. These were approved by the committee, and the Executive Secretary was instructed to have the form revised and 500 additional copies printed for use in 1956.

It was pointed out by the committee that it would be very helpful if the death certificate used in Ohio could contain a question, the answer to which would indicate whether or not the deceased, if a female, had been pregnant within the past 365 days. It was pointed out that quite often details of maternity cannot be ascertained from information on the present official death certificate. The committee then officially adopted a motion asking the State Department of Health to place the following statement on the death certificate at the earliest possible time: "If deceased was female, was she pregnant within the past 365 days? (Yes or No)"

ANALGESIA-ANESTHESIA

Further consideration was given to the question of nurses administering analgesia and anesthesia in obstetrical cases. After considerable discussion the committee adopted the following statement:

"Your committee recommends to The Council that, in view of the fact that the existing Ohio Medical Practice Act establishes the responsibility of the physician for the actual administration of an anesthetic and for the immediate presence of a physician when a registered nurse trained in anesthesia actually administers the anesthesia, therefore

"The Ohio State Medical Association, in collaboration with the Ohio Society of Anesthesiologists and the Maternal Health Committee of the OSMA, sponsor the establishment of an educational program in Ohio, including practical training for physicians and nurses in the ad-

ministration of adequate obstetrical analgesia and anesthesia."

The committee then adopted a motion authorizing the chairman to appoint a sub-committee for the purpose of trying to work out a practical solution to the problem confronting certain small hospitals on the matter of the administration of analgesia in obstetrical cases. In adopting the motion it was the intent of the committee that conferences would be held with persons who can give advice on this subject and that there should be representation on the subcommittee of both small and large communities; and that legal counsel should be secured, if necessary.

The committee considered two communications requesting it to support a recommendation that the rules governing maternity departments of hospitals be revised to permit the use of vacant maternity beds for hospitalization of non-infectious type of female patients to relieve bed shortages in hospitals. It was advised that the recommendation is being considered by the advisory committee to the Division of Child Hygiene, Ohio Department of Health.

By official action, the committee voted to respectfully request the Ohio Department of Health to seek the advice and comments of the Committee on Maternal Health of the Ohio State Medical Association in considering revisions, or in making revisions, in the rules and regulations governing maternity hospitals prior to submission of the proposed revisions, if any, to the Ohio Public Health Council for official action.

The committee then considered briefly the matter of developing a set of minimum standards of obstetrical and maternal care. Standards which have been developed in several other states, including Massachusetts, were reviewed in a general way. The committee decided to defer action on this until the next meeting.

Ohio Dentists Hold 90th Session in Cleveland

A record attendance of more than 2,500 was announced following the 90th annual meeting of the Ohio State Dental Association in Cleveland.

Victor L. Steffel, D.D.S., Columbus, took the post as president to succeed Herbert J. Hoppe, D.D.S., Cleveland. The president-elect is Theodore E. Lilly, D.D.S., Dayton, and the vice-president, Howard J. Niedhamer, Cincinnati. Earl G. Jones, D.D.S., Columbus, was reelected secretary-treasurer.

The 1956 meeting will be held in Columbus.

Public Relations and Economics . . .

Committee Reports to The Council; Studies and Reports on Matters Referred by House of Delegates; Reports Meeting with Pharmacists

A DETAILED report on actions taken at a meeting of the Committee on Public Relations and Economics on October 2, 1955, in the Columbus Office, was presented to The Council on December 11.

The Council officially approved the actions and recommendations of the committee, a digest of which is as follows:

Resolution H, referred by the House of Delegates at the 1955 Annual Meeting to The Council for study and subsequently referred by the Council to this committee, was discussed at length. The resolution recommended that the Association go on record as favoring hospital insurance in some co-insurance form. The committee felt that it could not make any decision on this subject at this meeting as it needed expert advice from various sources. Therefore, by official action, the committee deferred action until another meeting, at which representatives of Blue Cross and Ohio Medical Indemnity, as well as a representative of the Health Insurance Council, could be heard.

INSURANCE FORMS

The question of simplified, standardized insurance report forms was discussed at length. Participating in the discussion was Mr. Edward Willenborg, Executive Secretary of the Cincinnati Academy of Medicine, who attended the meeting by invitation.

It was the feeling of the committee that the agreement reached between the AMA and the Health Insurance Council did not solve the problem. It was felt that six forms were too many and that most of these forms asked questions which were unnecessary. The forms being used in Cincinnati, Cleveland and Canton were reviewed. Reference was made to an agreement apparently worked out in California between the California State Medical Society and the State Health Insurance Council consisting of two standardized forms.

The committee arrived at the following definite conclusions:

1. The so-called agreement between the AMA and the Health Insurance Council is not satisfactory and that the AMA should be urged to continue conferences on this matter.

2. That, if necessary, arrangements be made so that physicians throughout the state could secure forms from either Cincinnati, Cleveland or Canton for use in making reports to insurance companies.

3. That the Health Insurance Council be ad-

vised of these actions and requested to confer with the Association in the hope that a single standardized form can be worked out for the entire State of Ohio.

4. The solution of this entire question should be accomplished, if possible, on a national basis, but pending a national solution an effort should be made to work out a plan for Ohio which would involve a single standardized form.

The committee reviewed a report on the medical examination program being carried on at the General Electric Lamp Plant in Youngstown by Occupational Health Service. This report had been presented to The Council and referred by The Council to this committee for investigation. It was the feeling of the committee that a great deal of additional information is required. Therefore, by official action, the committee deferred action and decided to invite representatives of the General Electric Lamp Plant, representatives of the Occupational Health Service, and representatives of the Mahoning County Medical Society to appear before the committee at a later date to discuss this question.

HEALTH ORGANIZATIONS

A resolution adopted by the House of Delegates at the 1955 Annual Meeting, referring to various health organizations and agencies, was reviewed. It read as follows:

"WHEREAS, The Montgomery County Medical Society is deeply gratified by the splendid cooperation of its members and other residents of the county in the Salk Vaccine trials in 1954, and these members now that scientific evaluation has demonstrated the effectiveness of the vaccine have pledged full cooperation in the program of mass inoculations in 1955; and

"WHEREAS, In full awareness of the remarkable results of the vaccine trials, and as a result of two years of intimate association with the project, certain factors that can be detrimental to the public health and contradictory to sound scientific principles were noted, namely: Problems and policies which can be anticipated in projects conducted by large national health agencies, and therefore should receive the serious consideration of the medical profession in its efforts to improve the public health; and

"WHEREAS, Specifically, these problems and policies involving the large national health organizations are:

- "(1) Widespread promotion of a proposed health project before medical approval is secured and with such promotion or publicity the attend-

ant pressure for medical approval making objective scientific appraisal virtually impossible;

"(2) Setting up of rigid rules for conducting a project without sufficient flexibility to meet local situations;

"(3) Promotion of 'mass medicine' involving prevention, diagnosis or treatment of a single disease entity without regard to the 'whole patient,' a condition detrimental to the establishment of a sound patient-physician relationship;

"(4) Publicizing a single disease to an extent out of proportion to the importance of the disease and without regard to the individual's health as a whole, this problem becoming more acute as 'single disease' agencies increase in number and size and in their competition channel funds away from less dramatic but more deserving health problems; therefore

"RESOLVED, That the Ohio State Medical Association take the necessary steps to

"(1) Counsel with the various national health agencies so that they will secure proper scientific evaluation and approval of projects and on procedures for conducting them prior to public promotion of the projects.

"(a) Criteria for approval of procedures should include (1) sufficient flexibility of rules to meet local conditions, and (2) maintaining of patient-physician relationship as opposed to 'mass medicine' technique.

"(2) Actively discourage over-emphasis on a single disease by national health agencies in their health education and in connection with their fund raising.

"(3) Encourage such agencies to join federated fund raising organizations as an earnest expression of their willingness to be a community member.

"(4) Assist such agencies in determining fund raising goals based on actual need for funds.

"(5) Have its delegates to the American Medical Association recommend the above four objectives on a national scale."

After careful consideration it was the opinion of the committee that the first recommendation asking for proper scientific evaluation and approval of projects and procedures had already been disposed of by a resolution adopted at the June, 1955, session of the American Medical Association. Following is the action of the AMA House of Delegates on this question:

"WHEREAS, There are traditional methods by which investigators and scientists in all fields announce and critically review discoveries and applications thereof; be it

"RESOLVED, That we reaffirm our confidence in the established methods of announcing new and possibly beneficial methods in the treatment and prevention of disease; and be it further

"RESOLVED, That we reaffirm the need for the presentation of reports on medical research before established scientific groups, allowing free discussion and criticism, and the publication of

such reports, including methods employed and data acquired on which the results and conclusions are based, in recognized scientific publications."

It was the recommendation of the committee, by official action, that recommendations (2), (3) and (4) of the resolution should not be implemented inasmuch as they would antagonize large sections of the public and create bad public relations for the medical profession. The committee expressed a strong opinion that there should be close working relationships between the medical profession and all the health agencies and organizations and that if this is accomplished most of the problems which have caused misunderstandings can be eliminated or at least minimized. It was the belief of the committee that persons particularly interested in a single disease for personal reasons or otherwise would misunderstand action by the medical profession tending to discourage public interest in that particular disease. Also, the committee felt that the question of whether or not the solicitation of funds should be carried on through a single united appeal program or otherwise is a matter which has to be decided locally on the basis of local conditions, circumstances and sentiment.

The committee believes that there is not a need for carrying out recommendation (5) of the resolution inasmuch as the AMA already has taken specific action along these lines.

The committee reviewed a report by Dr. Robert E. Hopkins, Coshocton, Councilor of the Seventh District, on the United Mine Workers Health and Welfare program. The committee felt that it was not in a position at this time to act on Dr. Hopkins' recommendations. Therefore, it decided to devote another meeting to this question and to invite to the meeting Dr. Hopkins, representatives of the United Mine Workers Health and Welfare program and representatives of the Belmont County Medical Society for the purpose of getting their opinions and ideas.

Before adjourning the committee discussed in a general way the public relations aspects of the AMA opposition to including compensation for disability in the Federal Social Security Law.

Also, it discussed in a general way the suit brought by the Cleveland Academy of Medicine against the Hopkins Clinic, Cleveland, and the new developments in this case.

MEET WITH PHARMACISTS

On Saturday evening, October 1, 1955, at the Fort Hayes Hotel, Columbus, there was a conference of representatives of the Ohio State Pharmaceutical Association and the Committee on Public Relations and Economics.

Following dinner there was a general round-table discussion on various questions. The more important matters discussed were:

1. The possibility of preparing a form to be used by physicians for keeping records on polio

ANNUAL CONFERENCE OF COUNTY MEDICAL SOCIETY OFFICERS AND CERTAIN COMMITTEE CHAIRMEN TO BE IN COLUMBUS ON SUNDAY, FEBRUARY 12

Annual Conference of County Society Officers, Delegates and Chairmen of Legislative and Public Relations Committees, sponsored by the Ohio State Medical Association, will be held at the Neil House, Columbus, on Sunday, February 12, starting at 10:00 A. M.

Invitations are being sent to County Society presidents, presidents-elect, secretaries, OSMA delegates, and chairmen of local legislative and public relations committees.

Physicians in any one of these categories should check off February 12 on their calendar and plan to be in Columbus that day.

They can't afford to miss this vital conference, a detailed program on which will be sent to all expected to attend. The program will cover national legislation, especially proposed amendments to the Social Security Act; medico-legal questions (panel discussion); how to improve attendance at medical society meetings; ways the OSMA and AMA can help local societies on public exhibits, getting literature on public relations, etc.; functions, responsibilities and activities of legislative committees; how *The Journal* can help local societies and why it needs cooperation from local officers; need for strong local committees to work with OSMA committees; relations between medical societies and public health departments, and other matters of value and interest to local officers and committee chairmen.

Those who get invitations to the February 12 conference should send in their acceptance immediately to help the Columbus Office in making adequate arrangements for the complimentary luncheon and in setting up other details.

inoculations. (The OSMA committee stated that it would take this under consideration.)

2. That a joint statement, or statements, be prepared on the dangers of new drugs and their toxic effects; and on various poisons.

3. That a plan be worked out for interchange of speakers at state, district and local meetings.

4. That a plan be worked out for an exchange of exhibits at the annual sessions of the two organizations.

5. That a plan be worked out for the preparation of articles by representatives of both professions which could be published in the respective magazines of the two organizations.

6. The problem of "coded prescriptions"; telephones placed by pharmacists in physicians' offices; name of druggist on prescription blank furnished to physicians; the pharmacist who discusses prescriptions with patients; the writing of illegible prescriptions, were among the general mutual problems discussed.

Private Medical Schools Included In Grants of Ford Foundation

Included in the recent half-a-million dollar donation of the Ford Foundation to the nation's colleges, universities and hospitals, is a grant of 90 million dollars to be distributed among the privately-supported medical schools "to help them strengthen their instruction methods." The grant had not been broken down into specific allocations as *The Journal* went to press.

The Foundation said: "Unless the increasing financial needs of medical education are met, the present high standards of medical training in the United States will undoubtedly be lowered."

Congress on Industrial Health To Be Held in Detroit

The 16th Annual Congress on Industrial Health, sponsored by the Council on Industrial Health of the American Medical Association and local professional organizations, will be held in Detroit, Michigan, at the Sheraton-Cadillac Hotel, on Monday and Tuesday, January 23 and 24. This is an open meeting to which all physicians interested in the subject are invited.

On Sunday, January 22, preceding the Congress, the Council on Industrial Health of the AMA will meet in the morning and afternoon with State Medical Society Committees on Industrial Health, and in the evening with the Industrial Medical Association officers and directors.

Subjects to be discussed at the Congress on Monday include "Occupational Medicine in Industrial Relations," arranged in cooperation with the University of Michigan School of Business Administration and the Institute of Industrial Health; and "Medicine's Responsibilities in the Automotive Age," which will deal with automobile accidents and injuries.

At the dinner on Monday evening, Benson Ford, vice-president of the Ford Motor Company, will speak.

On Tuesday a program on the theme "Absence from Work Due to Non-Occupational Illness and Injury" will be presented by the Committee on Medical Care for Industrial Workers. This is a joint committee of the Council on Medical Services and the Council on Industrial Health of the American Medical Association.



**Activities
of the
1956
Annual Meeting
Will Center
Around These
Cleveland
Landmarks**



APRIL 10, 11, 12
Cleveland

1956 ANNUAL MEETING Ohio State Medical Association

Here are the main features in store for you:

- 13 Specialty Section Meetings Including Section on General Practice
- 5 Specialty Society Meetings
- General Sessions, at which subjects of broad interest to all physicians will be presented
- Medical Motion Pictures
- Seminar on Medical Writing
- The Annual Banquet
- The Scientific and Educational Exhibit
- The Technical Exhibit
- Meetings of the House of Delegates
- Alumni and Other Organization Get-Togethers
- Meetings of the Woman's Auxiliary
- And the many other benefits that go with getting together with your colleagues

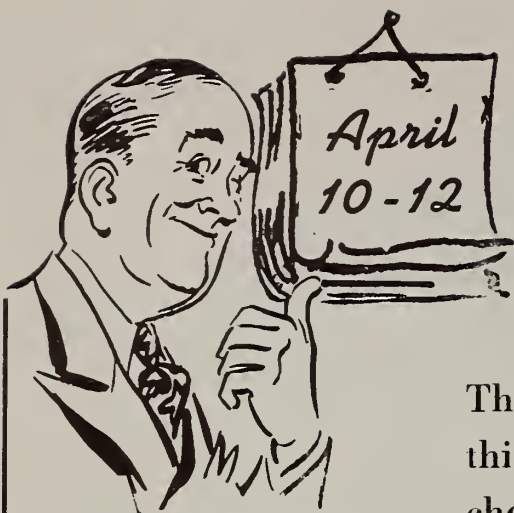
Facing Page (Top)
STATLER HOTEL
(Headquarters)

Where House of Delegates Will Meet and Annual Banquet Will Be Held

Facing Page (Bottom)
CLEVELAND
PUBLIC
AUDITORIUM

Where you will find Scientific Sessions and Exhibits

Turn to Accompanying Hotel Reservation Blank and make your reservation now with any one of Cleveland's many leading hotels



Here It Is — 1956

And Here Are Three Days To Mark

On That New Calendar

Then if you'll just clip the coupon at the bottom of this page, fill it in and mail it to the hotel of your choice, you'll be all set for the 1956 ANNUAL MEETING of the OHIO STATE MEDICAL ASSOCIATION IN CLEVELAND, APRIL 10-12. Here also is a list of leading downtown Cleveland hotels.

NAME AND LOCATION	SINGLE	DOUBLE	DOUBLE TWIN BEDS
STATLER HOTEL, Euclid & E. 12th (Headquarters Hotel)	\$6.00-13.00	\$10.00-16.00	\$11.00-18.50
AUDITORIUM HOTEL, 1315 E. 6th St.	\$4.50- 8.00	\$ 7.50-10.00	\$10.00-12.00
CARTER HOTEL, Prospect & E. 9th St.	\$4.75- 8.00	\$ 7.25-11.00	\$ 8.50-12.50
CLEVELAND HOTEL, Public Square	\$6.00-10.00	\$ 8.50-10.00	\$12.00-17.00
HOLLENDEN HOTEL, 610 Superior Ave.	\$5.00- 9.00	\$ 8.00-12.50	\$ 9.00-16.00
MANGER HOTEL, 1802 E. 13th St.	\$5.50- 9.00	\$ 7.50- 9.00	\$10.00-14.00
OLMSTED HOTEL, Superior & E. 9th St.	\$4.25- 9.00	\$ 7.00-11.00	\$ 8.50-11.00

Persons who desire additional accommodations are advised to specify their needs to the hotel of choice.
(All Rates Subject to Change)

HOTEL RESERVATION BLANK

Mail the coupon to hotel selected

Manager Cleveland, Ohio
(Name of Hotel)

You are requested to reserve the following accommodations during the period of the Annual Meeting of the Ohio State Medical Association, April 10, 11, 12, 1956, or for such other period as may be indicated herein.

☐ Single Room with Bath ☐ Double Room with bath Price

☐ Twin Bed Room with Bath ☐ Suite

Arriving April at A. M. P. M.

PLEASE VERIFY MY RESERVATION

Name

Address

APPLICATION

For Space in the Scientific and Educational Exhibit

1956 Annual Meeting • Ohio State Medical Association

CLEVELAND PUBLIC AUDITORIUM, CLEVELAND, OHIO, APRIL 10, 11, 12, 1956

Fill Out and Mail to:

A. D. NICHOL, M. D., *Chairman*

Committee on Scientific and Educational Exhibits

St. Luke's Hospital

Cleveland, Ohio

DEADLINE FOR APPLICATIONS . . . FEB. 15, 1956

1. Title of Exhibit:
2. Description or nature of exhibit (attach 200-word description to this blank).
3. Will radiologic viewing boxes be needed? If so, state number and size:
Number of boxes needed Size required
(Please indicate if you plan to furnish own view box.)
4. Will you require shelf space? If so, how much?
5. How much floor space will you require?
6. How much back wall space will you require?
7. How much side wall space will you require?
8. Other material or equipment required:
9. Name of exhibitor:
..... (Street) (City)
10. Name of institution cooperating in exhibit (if desired):
.....
.....
.....
.....

Booths will have a back wall and two side walls. The side walls of all booths will be four feet wide. The back wall of most of the booths will be 8 feet long; a few will be somewhat smaller. If an exhibitor needs more space, or a space with special dimensions, he should explain in detail in writing to the Exhibit Chairman. In most instances, the standard booth should be sufficient.

The height of the back and side walls will be eight feet. However, because of the standard shelf in all booths, only five and one-half feet of wall space will be suitable for exhibit material.

Do You Know? . . .

A study of the emissions from typical backyard trash burners shows that for every ton of rubbish burned, more than eight pounds of the emissions are phenols. That was one point brought out in a study of the Air Pollution Foundation conducted by Battelle Memorial Institute, Columbus.

* * *

Dr. George M. Wilcoxon, Alliance, recently made a 'round-the-world tour at the invitation of the Christian Medical Council for Overseas Work to visit mission hospitals as a medical and surgical consultant.

* * *

Officers of the Ohio State Radiological Society for the current year are the following: Dr. George R. Krause, Cleveland, president; Dr. Donald W. English, Lima, vice-president and president-elect; Dr. John R. Hannan, Cleveland, secretary; and Dr. Paul A. Jones, Youngstown, treasurer.

* * *

The Procter & Gamble Company has donated a million dollars to the Greater Cincinnati Hospital Funds, Inc. It was the largest single contribution to date toward the hospital fund goal of \$17,500,000.

* * *

Dr. Richard W. Vilter, University of Cincinnati College of Medicine, recently made a trip to Guatemala and Panama to study anemias associated with chronic nutritional deficiency diseases as consultant for the World Health Organization.

* * *

A total of 815 persons attended the eighth annual meeting of the American Association of Blood Banks held in Chicago, November 19-21. Registration represented 284 cities, 40 states and six foreign countries. Secretary of the organization is Miss Marjorie Saunders, LL. B., director of public relations, Baylor University Hospital, Dallas, Texas.

* * *

Dr. Benjamin S. Park, Painesville, is the new current president of the Board of Trustees of the Ohio Division, American Cancer Society.

* * *

A course designed for physicians devoting full or part time to the practice of ophthalmology will be held March 5 and 6 at the Ohio State University Union Building, 13th and High Streets, Columbus. Registration fee will be \$30. Physicians interested are invited to contact Dr. William H. Havener, acting chairman of the Department of Ophthalmology at the OSU College of Medicine.

Still Will Have Polio Problems, NFIP States In Appeal for Support of 1956 Drive

Ohio will still have polio problems in 1956. This observation has been made by the National Foundation for Infantile Paralysis in its appeal for support of the 1956 March of Dimes. The Foundation points out that the Salk vaccine has proved itself a major weapon against paralytic poliomyelitis but it has not yet won the war against the disease.

The following brief review of what the National Foundation has done in Ohio since it was organized in 1938 has been issued by the foundation:

There are 91 local chapters of the Foundation in Ohio. The first of the 3,100 local chapters of the National Foundation was formed in Coshocton in 1939.

Over \$11,460,000 has been spent by local chapters in Ohio for the care of polio patients.

A total of 198 National Foundation scholarships and fellowships has been awarded to Ohio residents.

Professional education grants in addition to Ohio institutions have totalled over \$309,000.

A considerable amount of research in virology and the treatment and after-care of poliomyelitis has been conducted in Ohio. Toward this research the March of Dimes has contributed over \$1,427,000.

Ohio institutions currently having March of Dimes grants are: Children's Hospital, Columbus; University of Cincinnati—Children's Hospital Research Foundation; and Western Reserve University. Among previous grant recipients, in addition were: Ohio State University, the Jewish Hospital, Cincinnati, and the Cleveland Rehabilitation Center.

Emergency aid in dollars and in equipment for polio patients has been generously supplied. In the first 10 months of 1955 a total of \$140,825 in emergency aid was sent to 19 Ohio chapters by the national headquarters of the National Foundation. In the year 1954 the amount was \$643,750 to 40 chapters.

A total of 46 tank respirators, 39 chest respirators and 36 rocking beds was sent into Ohio as emergency shipments in the first 10 months of 1955. The previous year Ohio got 113 respirators and 41 rocking beds.

Finally, 772,000 cc. of Salk vaccine were given to the state of Ohio without charge by the National Foundation to initiate its state-wide vaccination program in 1955.

The Foundation has set its goal for the 1956 March of Dimes nationwide at \$47,600,000.

The fifth Congress of Pan American Medical Women's Alliance will be held in Santiago and Vina del Mar, Chile, March 6-14.



Recognized as the two millionth member enrolled for coverage under Ohio Medical Indemnity, Mrs. Robert Menke, of Cincinnati, is shown above receiving a bond in token of the honor. With her are some of the key persons who participated in the celebration, left to right: Dr. H. T. Pease, member of The Council of OSMA; Dr. Carl S. Mundy, President of OMI; Dr. Charles L. Hudson, President of OSMA; Dr. L. Howard Schriver, former President of OMI; Mrs. Menke; Dr. Robert S. Martin, member of The Council of OSMA; Dr. C. C. Sherburne, Vice-President of OMI and Chairman of its Executive Committee; and Dr. H. M. Clodfelter, Past-President of OSMA.

Ohio Medical Indemnity Now Covers More Than Two Million Members

Ohio Medical Indemnity, the prepayment medical and surgical plan sponsored by the Ohio State Medical Association, now covers more than 2,000,000 members in the State. In recognition of having covered the two millionth member, OMI held an informal celebration at its new building in Columbus on December 6. Guest of honor was Mrs. Robert Menke, an employee of the Hartwell Frisch Restaurant in Cincinnati, who was accompanied by Mr. Menke. Mrs. Menke was presented a \$100 savings bond in recognition of being the two millionth member covered.

Guests of OMI for the celebration were members of The Council of the Ohio State Medical Association, key persons in the Ohio Blue Cross plans, members of the executive staff of the Ohio State Medical Association, wives of the foregoing persons, and others. Officers and members of the Board of Directors of Ohio Medical Indemnity with the executive staff of the organization were hosts.

Mr. Charles H. Coghlan, Executive Vice-President of OMI, was master of ceremonies. He presented Dr. Carl S. Mundy, Toledo, President

of OMI, and Dr. Charles L. Hudson, President of the Ohio State Medical Association, who spoke briefly on the accomplishments of OMI.

OMI in May of 1955 celebrated its 10th anniversary. It was incorporated in May, 1945, but did not start signing subscribers until January, 1946. Once started it has grown phenomenally, signing coverage of no less than 166,800 members in any one year and as many as 332,500. In 1954 as many as 225,606 members became covered.

OMI is the fourth largest Blue Shield Plan in the Nation, being exceeded only by New York, Pennsylvania and Michigan.

Residency in Allergy

An accredited residency in Allergy at the Ohio State University Health Center is available July 1, 1956. Facilities include in and out patients, adults and children, clinical and private services. There are excellent opportunities for experience in related sub-specialties including dermatology, pulmonary diseases and cardiology. For particulars, write John H. Mitchell, M.D., 1625 Perry Street, Columbus 1, Ohio.

Current officers of the Cincinnati Otolaryngological Society are Dr. Ervin S. Ross, president, and Dr. Joseph A. Lane, secretary-treasurer.

A. M. A. Clinical Session . . .

Ohio Well Represented at Boston Meeting on Program and in House of Delegates; Social Security and Other Important Matters Discussed

SOcial SECURITY, the report of the Committee on Medical Practices, grievance committees and revisions of the code of medical ethics were among the major subjects of discussion and action by the House of Delegates at the American Medical Association's Ninth Clinical Meeting held November 29 - December 2 in Boston.

OHIO DELEGATION

Ohio was represented in the American Medical Association House of Delegates by the following persons: Dr. A. A. Brindley, Toledo; Dr. Paul A. Davis, Akron; Dr. Carl A. Lincke, Carrollton; Dr. L. Howard Schriver, Cincinnati; Dr. C. C. Sherburne, Columbus; Dr. William M. Skipp, Youngstown; Dr. George A. Woodhouse, Pleasant Hill, and Dr. Herbert B. Wright, Cleveland. Accompanying the delegates to the meeting were Mr. George H. Saville, Public Relations director for the Ohio State Medical Association, and Mr. Hart F. Page, Assistant Public Relations director.

Several of Ohio's delegates served on reference committees of the House. Dr. Schriver was chairman of the Committee on Hygiene, Public Health and Industrial Health. Dr. Davis served on the Legislation and Public Relations Committee. Dr. Skipp served on the Committee on Miscellaneous Business. Dr. Woodhouse met with the Judicial Council of the AMA, of which he is a member, during the session.

Dr. Rolland J. Whitacre, East Cleveland, was a member of the House of Delegates, representing the AMA Section on Anesthesiology.

Mr. Saville and Mr. Page attended the Medical Society Executives' Conference on Sunday before the session and the Public Relations Conference on Monday.

OHIOANS ON PROGRAM

A number of Ohio physicians presented clinical talks during the AMA meeting, took part in the scientific exhibit or otherwise participated in the program, as indicated on the program announced before the meeting.

Dr. George W. Wright, Cleveland, participated in a presentation of Clinical Pathological Cases.

Dr. Ralph G. Carothers, Cincinnati, was chairman of the committee in charge of a Special Exhibit on Fractures.

A team from the Wright-Patterson Air Force Base, Dayton, presented an exhibit, entitled "Blood and Bone Marrow Patterns in the Differential Diagnosis of Disease." The team consisted of Drs. G. Douglas Talbott, Elmer Hunsicker and Jonah Li.

Dr. Herbert D. Chamberlain, McArthur, in

cooperation with the Ohio Academy of General Practice, presented the exhibit, "At Birth Diphtheria-Pertussis-Tetanus Immunization." This was a progress report, follow-up of a previous exhibit on the same subject.

Drs. Ralph E. Worden and James A. Patterson, Children's Hospital, Columbus, presented the exhibit, "Hydrotherapeutic Tanks—New Design All Purpose Tank."

Dr. George S. Hackett, Canton, presented the exhibit, "Low Back Pain."

Dr. A. Clair Siddall, Oberlin, presented the exhibit, "A New Frontier in Private Practice." The exhibit was a report of 11 years of investigation in which presumably well women were given semi-annual examinations.

DR. SOLLMANN HONORED

Of particular significance to Ohioans was the honor paid to Dr. Torald H. Sollmann, 81-year old Cleveland physician, at the opening session of the AMA House of Delegates. He was given a special award for his 50 years of service with the AMA Council on Pharmacy and Chemistry.

Dr. Sollmann, professor emeritus of pharmacology and materia medica at Western Reserve University School of Medicine, is a charter member of The AMA Council, having served continuously in an active capacity since its first meeting on February 11, 1905, and as its chairman since 1936.



DR. SOLLMANN

In the presence of members of the House, Dr. Gunnar Gundersen, chairman of the AMA Board of Trustees, presented Dr. Sollmann with a gold-printed citation for his "unselfish devotion and inspiring leadership."

One of his earliest accomplishments as a professor was to write the first English-language textbook on pharmacology. This 100-page work on laboratory experiments was a modest forerunner of his later, thousand-page "Manual of Pharmacology," which now is in its 7th edition and which is regarded as a standard textbook in all medical schools and research laboratories.

Dr. Gundersen in reviewing Dr. Sollmann's work said that he was a great influence in broadening education and in suppressing patent medicines and quackery.

Dr. Sollmann served as an Army consultant on

poison gas during World War I and twice has been a member of the AMA House of Delegates.

He is holder of several honorary degrees from Ohio State University and Western Reserve. He has been president of the Society of Pharmacology and Experimental Therapeutics and of the Federation of American Societies of Experimental Biology. He also is chairman of the Association of American Medical Colleges committee on aptitude tests for medical students.

Dr. Sollmann has had a part in compiling many publications sponsored by the Council on Pharmacy and Chemistry. One of its best known book publications is *New and Nonofficial Remedies*, which has been revised annually since 1907.

SOCIAL SECURITY

Major legislative policy action taken at the Boston meeting involved H. R. 7225, known as the Social Security Amendments of 1955. This bill, which was passed last summer by the U. S. House of Representatives and is now pending before the Senate Finance Committee, includes a proposal for federal cash benefits to selected individuals judged to be permanently and totally disabled. The House of Delegates adopted a substitute resolution proposed by the Reference Committee on Legislation and Public Relations to combine the intent of four resolutions and three supplementary reports of the Board of Trustees dealing with H. R. 7225 and other aspects of Social Security. The substitute resolution stated the following policy:

"That the American Medical Association reiterate in the strongest possible terms its determination to resist any encroachment upon the American system of medical practice which would be detrimental to our patients, the American people;

"That the American Medical Association urge and support the creation of a well-qualified commission, either governmental or private or both, to make a thorough, objective and impartial study of the economic, social and political impact of Social Security, both medical and otherwise, and that the facts developed by such a study should be the sole basis for objective non-political improvements to the Social Security Act, for the benefit of all of the American people.

"That the American Medical Association pledges its wholehearted cooperation in such a study of Social Security in the United States, and will devote its best efforts to procuring and providing full information on the medical aspects of disability, rehabilitation and medical care of the disabled, and

"That copies of this resolution be transmitted to the President of the United States, to all members of the Cabinet, to all members of the Congress, and to all constituent state medical associations."

OASI COVERAGE OF PHYSICIANS

In another action on social security, the House passed the following resolution designed to deter-

mine the exact attitude of physicians toward compulsory or voluntary coverage under the social security system:

"Whereas, Misunderstanding exists about the position of the medical profession on the question of the inclusion of physicians in the Old Age and Survivors Insurance provisions of the Social Security Act; therefore be it

"Resolved, That the House of Delegates of the American Medical Association recommend to state societies that they poll their entire membership on this question and that the results of the poll be transmitted to the Board of Trustees of the American Medical Association as soon as possible."

REPORT ON MEDICAL PRACTICES

The House passed a substitute resolution offered by the Reference Committee on Insurance and Medical Service to implement the findings and recommendations of the Committee on Medical Practices (Truman Committee), which studied the basic causes leading to certain unethical practices and unfavorable publicity. The resolution, adopted with the proviso that it is subject to review by legal counsel, includes the following points:

"That a Continuing Committee on Medical Practice be created in the American Medical Association to conduct a study of the relative value of diagnostic, medical and surgical services and to report its findings and recommendations to this House in the same manner as is now followed by other committees and councils of the Association;

"That this committee shall consist of five members of the House appointed by the Speaker, three of whom shall be general practitioners; . . .

"That this committee be directed to utilize all possible means to stimulate the formation of a department of general practice in each medical school;

"That the American Medical Association approve of the medical school teaching programs which afford the medical student opportunity for experience in the general practice of medicine;

"That the representatives of the American Medical Association on the Joint Commission on Accreditation of Hospitals be instructed to stimulate action by that body leading to the warning, provisional accreditation or removal of accreditation of community or general hospitals which exclude or arbitrarily restrict hospital privileges for generalists as a class regardless of their individual professional competence, after appeal to the Commission by the County Medical Society concerned;

"That this committee cooperate in every way and assist the Public Relations Department of the American Medical Association to present a program of public education designed to bring about a better understanding of all fields of medical practice, and

"That this committee use its full influence

to discourage any arbitrary restrictions by hospitals against general practitioners as group or as individuals."

In a complementary action on the same subject, the House also approved a supplementary report of the Board of Trustees which included the following suggestions:

1. All non-surgical groups should be asked for their suggestions and cooperation in carrying out a public education program on the value of diagnostic and medical work.

2. The various specialty boards should be encouraged to reappraise the practice restrictions on their board diplomates.

3. The American Medical Association should continue to discourage arbitrary restrictions by hospitals against general practitioners.

4. Organized medicine is "ready, willing and able to solve satisfactorily its own problems, and such assurance should be given to the American Hospital Association or any other group concerning itself with such problems."

GUIDES FOR GRIEVANCE COMMITTEES

The House approved the report of the Committee to Recommend Guides for Grievance or Mediation Committees and commended the committee for "their superb approach to this problem." Purpose of the guides is "to promote general uniformity of organization and function of grievance committees—and better understanding of their purposes—without interfering with the inherent autonomy of constituent medical associations. Constituent associations are therefore urged to implement these guides without delay."

The Reference Committee on Miscellaneous Business made the following recommendations which were adopted by the House:

"Your reference committee desires to support the recommendation that a brochure be published promptly which will outline the recommendations regarding the activities of Grievance Committees and that this brochure be given wide distribution.

"We recommend also that there be an appendix to this brochure in which additional, practical suggestions shall be included.

"We desire also to support the contention that there should be no equivocation concerning the naming of such committees and we recommend that a uniform policy be adopted in which they are called frankly 'Grievance Committees.'

"Finally, your reference committee recommends that because of the many variables, including the laws of the several states, which may influence the operations or procedures followed by State Grievance Committees, legal counsel shall be sought at the local level within the states."

MEDICAL ETHICS

A proposed revision of the "Principles of Medical Ethics and Precepts of Manners of the American Medical Association" was submitted to

the House by the Council on Constitution and By-Laws. The following reference committee suggestion was adopted by the House:

"In discussion it became evident that there was need for wide distribution of these principles and careful study of the proposed changes not only by this Reference Committee but also by all members of the House and in fact all members of the Association. It seemed desirable also that the two Councils (Council on Constitution and By-Laws and the Judicial Council) should meet in joint session to consider these proposals. Your Reference Committee therefore recommends that these proposals be tabled for further consideration at the next annual session of the House to be held in Chicago in June, 1956.

"In the meantime, it is recommended that these proposals in their entirety be widely publicized and that consideration be given to publishing, in *The Journal of the American Medical Association* and also in state medical journals, these proposed changes in the Principles. It is also recommended that consideration be given to the mailing of copies to each member of the Association. Finally, your Reference Committee recommends that prior to the meeting in Chicago next June the Council on Constitution and By-Laws and the Judicial Council meet in joint session to consider these proposed changes."

In another action on revision of medical ethics, the House also approved a plan requiring that all resolutions dealing with changes in the Principles of Medical Ethics shall be considered over a period between sessions of the House before final adoption.

MISCELLANEOUS ACTIONS

Among many other actions on a variety of other subjects, the House of Delegates also:

Recommended that the Board of Trustees give consideration to a dues increase for all Association members, with the increase designated for contribution to the American Medical Education Foundation;

Adopted a resolution on the practice of pathology declaring opposition to "the division of any branch of medical practice into so-called technical and professional services";

Recommended that further purchase and distribution of Salk polio vaccine be carried on by the presently available commercial avenues used for other immunizing agents, and that all vaccines, once proven, should enter the usual channels of distribution;

Approved appointment of an AMA committee to study the prevention of highway accidents;

Commended the Woman's Auxiliary of the AMA for its financial contributions in support of medical education and requested the Auxiliary to continue its active efforts;

Commended the Sears Roebuck Foundation for its thoughtfulness and foresight in sponsoring

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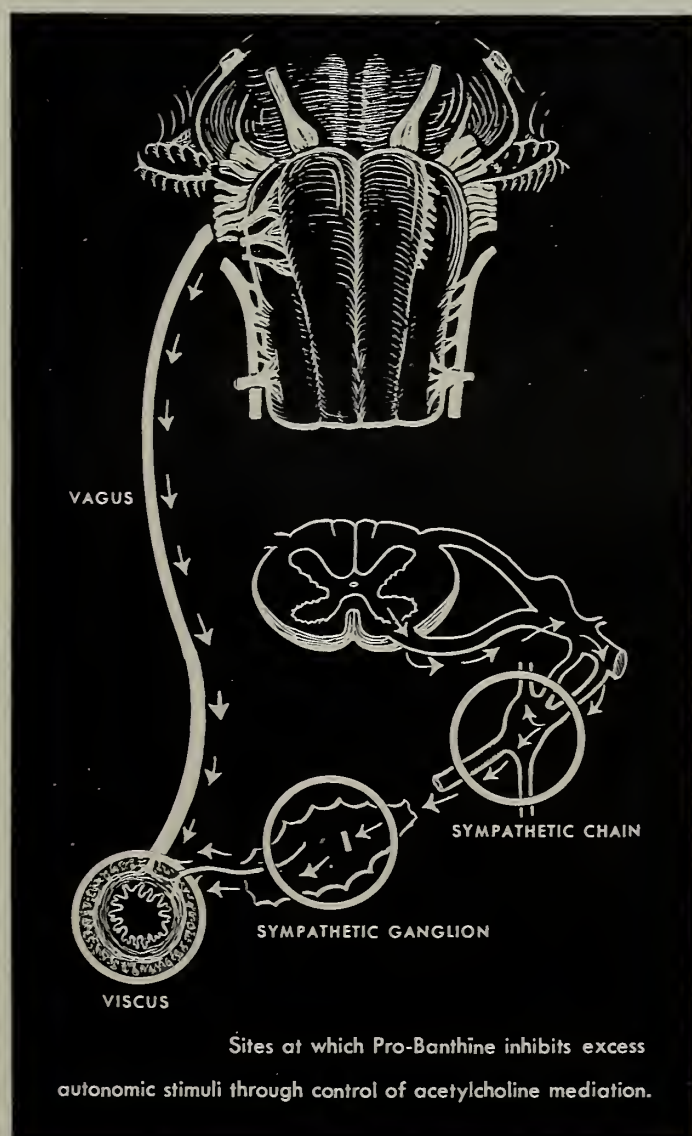
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Therapy with Pro-Banthine is remarkably free from reactions associated with parasympathetic inhibition. Dryness of the mouth and blurred vision are much less common with Pro-Banthine than with other potent anticholinergic agents.

In Roback and Beal's² series "Side effects were almost entirely absent in single doses of 30 or 40 mg. . . ."

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For the average patient one tablet of Pro-Banthine (15 mg.) with each meal and two tablets (30 mg.) at bedtime will be adequate. G. D. Searle & Co., Research in the Service of Medicine.



1. Schwartz I. R.; Lehman, E.; Ostrove, R., and Seibel, J. M.: *Gastroenterology* 25:416 (Nov.) 1953.
2. Roback, R. A., and Beal, J. M.: *Gastroenterology* 25:24 (Sept.) 1953.

Clinical trial packages of Pro-Banthine and the new booklet, "Case Histories of Anticholinergic Action," are available on request to . . .

SEARLE

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Chicago 80, Illinois

the new plan for financial assistance in establishing medical practice units;

Received progress reports from the Commission on Medical Care Plans and from the AMA Law Department on its studies of professional liability;

Approved a Board of Trustees recommendation that the State Journal Advertising Bureau be separated from the American Medical Association and be given full autonomy;

Congratulated the physicians of Iowa for their efforts in supporting the position that the practice of medicine is the right of the individual, and

Approved the selection of Minneapolis for the 1958 Clinical Meeting and Chicago for the 1960 Annual Meeting.

OPENING SESSION

Dr. Elmer Hess, AMA President, told the opening session of the House that complacency should be regarded as the medical profession's greatest enemy. Although good progress is being made in informing the public and the profession of the objectives of organized medicine, he said, educational efforts must be intensified and the list of physicians' tangible accomplishments for the health benefit of the public must be increased.

Dr. Leo H. Bartemeier, chairman of the AMA Council on Mental Health, told the House that the new Joint Commission on Mental Illness and Health will be ready to embark on its nationwide study and re-evaluation of the human and economic problems of mental illness after the first of the year. Dr. Bartemeier, who is chairman of the Board of Trustees of the Commission, appeared before the House to explain the functions of the new commission, which was organized to carry out the Mental Health Study Act passed by Congress earlier this year without a dissenting vote in either house.

AMEF CONTRIBUTIONS

The AMA Board of Trustees announced that it again has appropriated \$100,000 to be contributed to the American Medical Education Foundation for the support of medical schools. The California Medical Association presented a \$25,000 check to the AMEF, and the Utah State Medical Society announced an \$11,000 contribution.

New Members of O. S. M. A.

The following are the names of the new members of The Ohio State Medical Association since November 1, 1955. The list shows the county in which they are affiliated, city in which they are practicing, or temporary address in cases where physicians are taking postgraduate work.

BUTLER COUNTY

Louis B. Gaker, Middletown

COLUMBIANA COUNTY

Janis Lauva, Wellsville
Augustine A. Peller,
Wellsville

CUYAHOGA COUNTY

Robert W. Dole, Cleveland
Albert C. Lammert,
Cleveland
John Hopkins Neyer,
Cleveland
Reich Leis Watterson, Jr.,
Cleveland

DELAWARE COUNTY

Robert S. Caulkins, Jr.,
Delaware
Don K. Michel, Delaware

HAMILTON COUNTY

Mark S. Dine, Cincinnati

HIGHLAND COUNTY

Glenn B. Doan, Greenfield

LAKE COUNTY

Ralph F. Askam, Jr.,
Willoughby
William E. Barratt,
Painesville
Harry A. Killian,
Willoughby

LUCAS COUNTY

Ojars Podins, Toledo

MEDINA COUNTY

Rupert A. Schroeder,
Wadsworth

SENECA COUNTY

John G. Leahy, Tiffin

SUMMIT COUNTY

Carl F. Brandfass,
Cuyahoga Falls
Mary Elizabeth Dufner,
Akron
Mortimer A. Gallagher,
Akron
Robert C. Hunter, Akron
Emmett P. Monroe,
Cuyahoga Falls
James C. Oberholtz,
Akron
John E. Rhodenbaugh,
Bath
Marvin J. Sakol, Akron
William C. Sampson,
Akron
Benjamin F. Suffron,
Akron

TRUMBULL COUNTY

Donn F. Covert, Warren
James W. Loney, Warren

Two Insurance Heart Research Grants Awarded to Ohio Institutions

Two heart research grants worth a combined \$33,000 have been awarded in Ohio by the Life Insurance Medical Research Fund. Nationwide, grants by the fund for 1955 amount to \$929,400, the largest for any year so far. This year's grants bring to \$7,209,103 the total of the Fund's allocations for heart research to date.

Ohio awards were as follows:

University of Cincinnati College of Medicine, for research by Dr. William D. Lotspeich on kidney reabsorption of ketones, \$16,500.

Western Reserve University School of Medicine, for research by Dr. W. F. H. M. Mommaerts on chemical and molecular phenomena in muscular contractility, \$16,500.

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Medical Director



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The ataractic, tranquilizing action of 'Thorazine' can reduce the anguish and suffering associated with bursitis. 'Thorazine' acts not by eliminating the pain, but by altering the patient's reaction—enabling her to view her pain with a "serene detachment" . . . Howell and his associates¹ reported: "Several of [our patients] expressed the feeling that ['Thorazine'] put a curtain between them and their pain, so that whilst they were aware that the pain existed, they were not upset by it."

'Thorazine' should be administered discriminately and with the care to be observed with all serious medication. Consequently, it is important that the physician, before prescribing 'Thorazine', be fully conversant with the available literature.

Smith, Kline & French Laboratories, Philadelphia

1. Howell, T.H.; Harth, J.A.P. and Dietrich, M.: *Practitioner* 173:172.

*T.M. Reg. U.S. Pat. Off. for chlorpromazine, S.K.F.

New Certificates of Birth and Death . . .

Revised Forms Are Now Available From Local Health Commissioners;
Physicians Requested To Obtain New Form and Return Obsolete Ones

THE Ohio Department of Health has revised its Certificate of Birth and Certificate of Death and copies of the new forms are now available through local health departments, Dr. Ralph E. Dwork, director of the Department, announced. All occurrences subsequent to January 1 should be reported on the new forms.

Physicians are requested to send the obsolete forms in their possession to the local registrars of vital statistics where such forms can be used for issuance of copies of birth and death certificates filed since 1949.

The physician's record book has been revised to conform with the items as they appear on the revised certificate of live birth. Physicians and hospitals are encouraged to use the physicians record book as a means of obtaining the necessary information required for the completion of birth certificates.

The revision of the standard certificates was made in consultation with state health officers and registrars of vital statistics, national and state medical societies, funeral directors' associations; various Federal agencies and private organizations concerned with the legal, medical, public health, social welfare and demographic uses of vital records, according to W. H. Veigel, chief of the Division of Vital Statistics of the Ohio Department of Health.

The new standard certificates were endorsed by the Public Health Conference of Records and Statistics and the American Association of Registration Executives.

Every 10 years the standard birth and death certificates are revised by the National Office of Vital Statistics. The previous standard certificates were introduced in 1949 and, normally, the next revision would take place in 1959, Mr. Veigel said. The revision date has been moved to the middle of the decade so that the new forms may be well established by the time the decennial census is taken.

SLIGHT MODIFICATION

Experience with the standard certificates used previously indicated that the format was satisfactory and that only a few items required modification. On the live birth certificate, and on the death certificate, an item has been added indicating farm or nonfarm residence of the parent of the deceased. Also, the method of asking for information as to the place of occurrence and residence has been revised to utilize a check box to indicate location inside or outside city limits.

The farm residence question is a simple one,

requiring no special definitions of farm. The informant is asked to follow the common understanding of what a farm is.

The resulting farm residence data will fill an important gap in the preparation of population estimates in intercensal years and in the study of health and safety conditions in the farm population.

The change from "How many children were stillborn?" to "How many fetal deaths (fetuses born dead at any time after conception)?" was made on the new standard certificate of live birth.

The medical certification on the standard certificate of death has been revised slightly. The principle of reporting a sequence of causes which leads to the underlying cause of death remains the same; and the form still follows the international form of medical certification.

INSTRUCTIONS SIMPLIFIED

The instructions to the physician have been simplified. The items, "Date of operation" and "Major findings of operation," have been deleted. They were used chiefly in coding cause of death, and apparently served to confuse rather than improve reporting of the cause of death, Mr. Veigel said.

The Ohio Vital Statistics Law provides that the certificates of birth and death shall contain such items and information as may be required by the standard certificates and such additional items and information as the Public Health Council, by regulation, may prescribe. In addition to those items required by the standard certificates, the council adopted regulation 243 which provides that the following additional information be given on the certificate of birth: (1) Length of pregnancy in weeks; (2) Weight at birth; (3) Legitimate, yes or no; (4) Congenital malformation, yes or no; (5) Mother's mailing address. That information is for statistical use only and is not considered as being a part of the certificate in making a certification of birth.

Regulation 243a requires that the following additional information shall be given on the certificate of death: (1) Name of embalmer, and (2) License number of embalmer.

ACCURACY IMPORTANT

Mr. Veigel emphasized the importance of birth and death certificates being filled out carefully and accurately. The birth certificate is a fundamental document to any person who is required to show proof of age, or family relationship. It is routinely used when a child enters school, applies

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classroom

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for voting registration, obtains a work permit, prove legal dependency, receive insurance payments, etc.

The birth certificate provides information on which health departments base their plans for immunization of children, care of crippled children, evaluation of need for health facilities, effectiveness of infant care, etc. It provides information for many other statistical reports.

The death certificate is of primary importance to the family which finds itself under necessity of establishing the fact and date of death, in claiming life insurance, pensions, settling of estate, etc. Death certificates and the information they contain are important sources of many statistical studies.

The Ohio Department of Health in April, 1955, announced also a new form of the Certificate of Stillbirth (see May, 1955, issue of *The Journal*, page 481).

Iowa Court Rules That Hospitals Which Profit From Services of Physicians Are Guilty of Corporate Practice

Of nationwide significance is the recent Iowa District Court ruling that hospitals which employ doctors and profit from their services are guilty of the corporate practice of medicine. The decision was made when the District Court upheld a year old opinion of the Attorney General, after the Iowa Hospital Association and certain hospitals brought suit against the Attorney General, the State Board of Medical Examiners, the Iowa Association of Pathologists and certain individuals. There is a strong possibility the decision will be appealed to the Iowa State Supreme Court.

The particular question involved in the case was stated as follows in the court decision: "Whether or not the plaintiff hospitals are engaged in the illegal corporate practice of medicine in purveying to patients in said hospitals medical services in the form of laboratory procedures and x-ray procedures for compensation." Among the court findings was "that pathology and radiology are recognized specialties in the practice of medicine." The Iowa Code forbids splitting of professional fees without the consent of the patient.

Among the conclusions of the court were the following which are quoted in part:

"... That the pathologist or radiologist by permitting a hospital to bill for medical services in the name of the hospital without the consent of the patient or his legal representative, violates the provisions (of the Iowa Code)."

"... That the work done by the pathologist, radiologist, and the technicians working in the pathology and x-ray laboratories, constitutes the practice of medicine."

"That under the Iowa law the privilege of

practicing medicine is a personal one requiring qualifications which cannot be met by a corporation."

"That the provisions of (the Code) do not grant hospitals any right to practice medicine by the operation of pathology and x-ray laboratories in the manner shown by the evidence."

"That plaintiff hospitals are not excluded from the requirements of the Iowa practice acts in regard to the practice of medicine on the basis that they are non-profit corporations or because of long standing custom and inactivity on the part of those charged with enforcing the law, or because of public policy in the absence of legislative enactment."

"That plaintiff hospitals under the Court's findings of fact and conclusions of law have been engaged in the unauthorized, unlicensed and illegal practice of medicine."

"That under the Court's findings of fact and conclusions of law the pathologists and radiologists have been violating the provisions of (the Code)."

"The Court does not intend that any findings or conclusions herein affect in any way the obligations of public hospitals under (the Code), as well as the State Hospital at Iowa City, to provide medical treatment for indigent persons or tuberculous patients as provided in Chapter 254 and Chapter 255 of the Code wherein medical treatment is to be provided by hospitals of that category to patients of certain entitlement, nor as to the operation by the State of mental or other hospitals authorized by law."

"The Court is not to be understood as holding the plaintiff hospitals cannot own and maintain the facilities of pathology and x-ray laboratories and receive just compensation for the use thereof, as certainly these are essential and necessary parts of a modern hospital, not that the operation of said laboratories within the law need affect the care and treatment to be given the patients."

The 31-page decision (No. 63095, Equity) was given in the District Court of the State of Iowa in and for Polk County, (Des Moines). The Judge was C. Edwin Moore.

* * *

This decision of the Iowa Court is particularly interesting in Ohio where another case dealing with the corporate practice of medicine is now before a court. This is a case pending in the Cuyahoga County Common Pleas Court in which a group of physicians, with the consent and support of the Academy of Medicine of Cleveland, have brought suit to restrain the Hopkins Clinic, Inc., and thereby test the legality of the practice of medicine by a non-profit corporation in Ohio.



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H.R. 7225— Its Dangers . . .

Warnings About Proposed Amendments To Social Security Act, To Provide Disability Payments, Emphasized in AMA Trustees Report

THE attitude of the American Medical Association on proposed amendments to the Federal Social Security Law was one of the most important policy decisions made by the House of Delegates at the interim session in Boston, November 29 - December 1.

In the roundup story of the session appearing on page 70 of this issue of *The Journal*, brief reference is made to the action of the House in adopting a substitute resolution on the subject presented by the Reference Committee on Legislation and Public Relations.

CALL FOR OBJECTIVE STUDY

In effect, the resolution advocated no more changes in the Federal Social Security Law until a well-qualified commission, either governmental or private, or both, has made a thorough, objective and impartial study of the economic, social and political impact of Social Security, both medical and otherwise. The wholehearted cooperation of the American Medical Association was pledged in such a study.

One of the bases for this resolution was a supplementary report by the Board of Trustees to the House of Delegates entitled "Social Security Amendments of 1955."

The report stated that every member of the American Medical Association would receive a personal letter from Dr. Elmer Hess, President of the AMA, dealing with the Social Security Amendments of 1955, and a pamphlet entitled "Clinical Analysis of H.R. 7225."

Believing that Ohio physicians will want to be fully informed on this important and controversial subject, *The Journal* presents the following excerpts from the supplementary report of the Board of Trustees:

BOARD'S REPORT

"This informational report by the Board of Trustees to the House of Delegates concerns a legislative problem which the Board considers to be the most serious faced by the medical profession in many years. It involves a bill introduced too late in the first session of the 84th Congress for the House of Delegates to act on it last June. The bill in question is H. R. 7225, known as the Social Security Amendments of 1955.

"This legislation first was rushed through the House Ways and Means Committee meeting in brief executive session without public hearings. Then it was passed by the House of Representatives, on July 18 by a roll call vote of 372 to 31, under a procedure suspending the rules, barring amendments, limiting debate to 40

minutes and requiring a two-thirds vote for approval. This precipitate action was taken despite the protests of numerous Congressmen who demanded open hearings and careful consideration of the bill.

"Fortunately, the Senate Finance Committee refused to be stampeded into hasty action on a bill of such major importance. The Senate Finance Committee decided to postpone action until the second session of the 84th Congress, at which time extensive public hearings will be held.

WHAT BILL DOES

"H. R. 7225 would, among other things, lower the Social Security retirement age for women from 65 to 62; expand compulsory Social Security coverage to all self-employed professional groups except physicians, and raise Social Security taxes over and above the increases already scheduled for the next twenty years. These provisions in themselves pose a variety of questions which call for careful study of their ultimate effects on the scope, philosophy and financial stability of our Social Security system.

"From the standpoint of the medical profession, however, the most controversial parts of the bill are the sections which would extend OASI Survivor's benefits for permanently and totally disabled children beyond the age of 18 and make permanently and totally disabled persons eligible to receive their Social Security retirement benefits at age 50 instead of 65. These sections are of particular concern because they would directly affect physicians and the practice of medicine. Under the provisions of this bill, physicians—both in determining total and permanent disability and in providing the rehabilitation services required by the legislation before the cash benefit is paid—presumably would be under federal regulation and would be paid for their medical services—at least in part—out of federal funds.

EFFECT ON PHYSICIANS AND PATIENTS

"By providing a disability benefit as a right through the OASI system this legislation would subject physicians to government regulations in making disability determinations and rendering rehabilitation services. Furthermore, constant pressures from government, administrators and patients seeking disability certifications would cause increasing harassment of the medical profession.

"This bill clearly is another step in the extension of government control over the medical profession.

"More important, it raises grave questions re-

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1. Pollock, B. E., and Pruitt, F. W.: *Ann. J. M. Sc.* 226:172, 1953.
2. Batterman, R. C.: *Am. Heart J.* 48:780, 1954.

lating to the welfare of our patients. Its threat to the profession is only significant if it conflicts with our ability to discharge our obligations to those we serve. It would classify and certify as hopeless many of those to whom adjustment to a new way of life offers the only hope of recovery and rehabilitation. In the guise of aiding those disabled, it would hamper their return to useful life. The emphasis on the cash benefit would hinder rather than promote rehabilitation of the disabled.

ANOTHER SOCIALISTIC STEP

"Thus, the most serious question raised by H. R. 7225 concerns this long range effect on the future of medical practice. Your Board of Trustees strongly suspects and fears that this proposal, if enacted, would prove to be just another piece in the pattern of social planning leading inevitably to permanent disability benefits at any age, cash benefits for the temporarily disabled, direct federal payments for hospital and medical costs, and then, ultimately, a full-fledged system of tax-paid medical care.

ALTERNATIVE PROPOSALS

"In the opinion of the Board, the AMA can reasonably support the following program:

"(1) The social security issue, once and for all, should be taken out of politics. It is much too complex a problem, with too many serious implications for the future of this country, to continue to be considered on the basis of political expediency every two years at election time.

"(2) There should be an objective, thorough study of social security in all its present and future aspects, medical and otherwise. The American Medical Association will do everything in its power to promote the idea of such a study and to cooperate by conducting more extensive research on disability, rehabilitation and medical care.

"(3) The facts developed by such a study should be used as the basis for a sound national decision on this vital issue. Only by getting a clear picture of ultimate liabilities and costs—economic, social and political—can the American people make an intelligent decision on further expansion of the Social Security system.

PUBLIC BECOMING CONCERNED

"Fortunately, a growing number of organizations and individuals are becoming concerned over the continuous politically-inspired expansion of the Social Security system. Like the AMA, they see that the system now has reached the point where any further changes may have a profound influence on the nation's economic, social and political future. They agree that the time has come to ask what social security should accomplish and where it should stop. Many such groups and individuals, sufficiently aroused nationwide, may bring about the sober study needed to promote a stable and sound system."

Federal Medical-Health Spending Passes \$2¼ Billion Mark

The Washington office of the American Medical Association recently issued an illuminating report on federal medical-health spending for fiscal year 1956 (July 1, 1955, to June 30, 1956). It is a factual study based on budgets, appropriation bills, and information obtained directly from government agencies and departments.

The report shows that this year the Department of Health, Education, and Welfare with almost a 1/3 increase reaches a new high mark in spending for health and medical programs—more than half a billion dollars. Only two other agencies' medical spending is over the half billion figure, Defense Department and Veterans Administration. Compared with last year, HEW is spending 32 per cent more in the health fields.

Total federal health spending also will reach a new high of over two and one quarter billion dollars during the current fiscal year, about \$2,268,800,000 a 6.4 per cent increase over last year. Uncle Sam puts up \$15 of every \$100 spent by the American people (publicly or privately) for health and medical purposes, from purchase of toothpaste to financing cancer research.

Following are the total medical-health budgets of federal departments, agencies and commissions for the current fiscal year as compared with fiscal 1955:

Agency	Fiscal 1956	Fiscal 1955
Department of Defense	\$ 818,104,500	\$ 844,087,500
Veterans Administration	790,185,800	754,819,344
Department of Health, Education and Welfare	526,935,400	399,180,500
Federal Civil Defense Admin.	30,450,000	28,755,000
Atomic Energy Commission	27,700,000	26,800,000
International Cooperation Admin.	25,441,000	31,137,900
Department of State	13,669,790	12,607,667
Department of Labor	7,336,000	7,171,857
Federal Employees Health Program	6,000,000	6,000,000
Department of Interior	5,770,000	5,837,909
Panama Canal Zone	5,702,900	5,800,503
National Science Foundation ..	5,000,000	3,600,000
Department of Treasury	2,990,000	2,770,000
Department of Justice	1,470,000	1,277,362
Federal Trade Commission	1,000,000	1,000,000
Civil Service Commission	382,600	350,000
Department of Commerce	277,586	299,733
National Advisory Committee to Selective Service	180,000	147,444
President's Comm. for Handicapped	130,000	87,653
Health Resources Advisory Comm.	101,000	90,000
TOTALS	\$2,268,826,576	\$2,131,820,372

The International Academy of Proctology is again offering annual awards for the best unpublished contributions on proctology or allied subjects. Awards will be presented at the annual convention dinner dance of the International Academy of Proctology, April 26, at The Drake Hotel, Chicago. All entries must be received not later than February 1 at the academy's headquarters, 147-41 Sanford Ave., Flushing, N. Y.

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PROCTOLOGY AND GASTROENTEROLOGY

A combined course comprising attendance at clinics and lectures; instruction in examination, diagnosis and treatment; pathology, radiology, anatomy, operative proctology on the cadaver, anesthesiology, witnessing of operations, examination of patients preoperatively and postoperatively in the wards and clinics; attendance at departmental and general conferences.

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In Our Opinion:

Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

AGE GROUPS SHOULD BE OBSERVED IN GIVING POLIO SHOTS

There have been some disturbing reports from different parts of the state that some physicians are failing or refusing to observe the understanding that polio vaccine should be given at this time only to children from one year to 10 years and pregnant women. Doesn't appear to be cricket, does it? In fact, the over-all supply of vaccine is not large enough to warrant giving vaccine to those outside the more susceptible groups. Experts have given a lot of thought to this and have made recommendations. It seems, in our opinion, that it is extremely important for physicians to be cooperative at this time. Rigid government control of the vaccine is still in effect. This should be lifted as soon as possible. If the rules and suggestions of government agencies are ignored, lifting of controls certainly will not be expedited. In fact, the very opposite might occur, i. e., tightening of controls for a longer period. The medical profession is confronted with a situation which should be handled in a practical manner and with foresight.

BIE DAY—HAS YOUR SOCIETY A PART IN IT?

If the Chamber of Commerce of your city sponsors a "Business-Industry-Education Day" get your County Medical Society to take part in it.

The idea is to give the school officials and teachers of the city information on the activities of the business and professional people of the community. It's a whale of a fine public relations and educational program. Here's what the *Toledo Academy of Medicine Bulletin* had to say about BIE Day which was celebrated in Toledo recently:

"Once again your Academy was host to a group of local teachers—90 this year—at the annual Chamber of Commerce Business-Industry-Education Day. These teachers were briefed by a number of our members on the many functions and services of our Academy and were then shown our building. As a second half of the program, the group was divided and taken on tours of Flower Hospital and Toledo Hospital.

"Attesting to its value were a number of letters of appreciation received at the Academy. The theme reiterated in the letters—'We had no idea of the many services rendered by the Academy'—shows that the purpose of the program was accomplished. The public relations value of this Day to the medical profession is evident."

MANSFIELD PHYSICIANS USE THE P. R. APPROACH

When 160 postal employees and members of their families attending an outing in Richland County became ill with food poisoning and had to be treated at the Mansfield General Hospital, the physicians of Mansfield were pretty busy, to put it mildly.

After it was all over, the hospital staff voted to make no charge for professional services rendered to any of the 160 who were treated during the first 24 hours.

Obviously, the affair created quite a sensation in Mansfield. For that reason the action of the physicians "because of the emergency" won plenty of fine comment from the people of the community. Public relations in action wasn't it?

BETTER GET A FILM CATALOG

Do you know that the AMA issues a catalog of medical and health films for showing at either professional or lay group meetings?

A revised catalog has just been issued.

Better write the AMA Committee on Medical Motion Pictures at 535 N. Dearborn Street, Chicago, for a copy. It might come in handy.

CHARGING COLLEAGUES A FEE FOR SERVICES

Frequently a physician—more frequently a physician just starting practice—wants to know whether or not he should charge a colleague for professional services. The question is even a bit more difficult when the colleague carries medical insurance.

Referring to the Principles of Medical Ethics, here is what the Judicial Council of the American Medical Association has to say on the subject:

"Chapter IV, sections 1 and 2 of the Principles state that a physician should cheerfully and without recompense give his professional services to physicians or their dependents. These sections recognize, however, that such services may take the attending physician away from his accustomed field of practice and cause him pecuniary loss. They provide, therefore, that if the physician who received medical care is in easy financial circumstances he may offer compensation to the physician who attended him for traveling expenses, which compensation may include an amount to provide in part for loss of time away from accustomed practice.

"The Judicial Council in its report to the House of Delegates at its Los Angeles, 1951, session stated, 'If a physician or his dependents

have insurance providing for medical or surgical care, then, in the opinion of the Council, a physician who renders such service may accept the insurance benefits without violating the provisions of Chapter III [now Chapter IV], sections 1 and 2 of the Principles.' The Council reaffirms its 1951 statement."

P.S. It could have been pointed out by the Judicial Council that some physicians caring for other physicians who have insurance, contribute the amount paid to them by their colleague from the insurance benefits to some medical, hospital or scientific fund used for promotion of medical and health activities.

POLICY ON IMMUNIZATIONS AND EXAMINATIONS

The attractive little pamphlet, "The ABC's For School Health Committees," prepared by the Committee on School Health of the Ohio State Medical Association and distributed to similar committees of County Medical Societies contains some exceedingly informative material and recommendations.

Any local committee which really has its heart in its job will be able to chalk up a good record if it will only follow the ideas and suggestions found in the pamphlet.

Among other things, the pamphlet carries the text of the official OSMA policy, adopted by The Council in April, 1955, on immunizations and examinations involving preschool and school children. Here it is, as it's important for all physicians to be familiar with it:

"1. A check on immunizations immediately prior to the child's entry into school is recognized as a function of school health supervision. However, parents should have primary immunizations done at the appropriate time in infancy, and this should be stressed by the family's personal physician.

"2. Each child should have necessary booster immunizations before entering school and thereafter as indicated.

"3. Each child should have a medical examination adequate for his or her welfare, proper school adjustment and protection of public health prior to entering school, and periodically, or as indicated by special need, during his or her school career.

"4. These examinations and immunizations should be done in the office of the family's personal physician whenever feasible.

"5. The local board of education should be encouraged to adopt regulations to enable the school to meet its responsibility in accomplishing these objectives."

WHAT ABOUT MEDICATION OF ATHLETES?

What about this question of medicating athletes for the purported purpose of building them up physically so they can do a better job in athletic competition? It's a question which comes up frequently in many communities in this day of keen interscholastic competition.

Plenty of arguments, pro and con, have been presented. In the end, the decision should be based on what is believed to be (1) best for the individual athlete and (2) the practice of good medicine.

You may be interested in knowing what some real authorities have to say on the matter. In March of this year, the Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association expressed its opinion on a number of questions of this kind. Its resolution read as follows:

"In 1953 the Joint Committee on Health Problems in Education, with reference to the influence of oxygen administration to athletes, concluded that valid scientific evidence in support of the value of oxygen in athletic competition is lacking. The committee was of the opinion then, and continues to feel, that the anticipation of help from oxygen might encourage the athlete to exert himself beyond the limits he has learned to expect from instinct and experience, and, therefore, recommended that the use of oxygen for such purposes be disapproved. Instances similar in nature have been reported involving the administration of drugs to stimulate athletes to greater activity or to narcotize an injured part for purposes of continuing play. These practices, along with mass medicine such as the administration of vitamins and other products, in the opinion of the committee, constitute poor medicine and worse education. They likewise represent an unfortunate ethical practice. The committee, therefore, believes that such practices should be disapproved."

WHEN IN DOUBT, BETTER CHECK

As the Public Relations Department of the AMA has pointed out, quite often a public relations problems carries with it an intraprofessional problem. It cited this example:

At the conclusion of his residency a young doctor moved to another state and secured a license to practice medicine. The local Lions Club in the little town in which he was setting up practice wanted to help him get started. Its members offered to print and circulate announcement cards to townspeople. The young doctor was uncertain whether such an action was ethical, and there was no other doctor practicing in the town to provide him with an answer. He checked with the county medical society and learned that such practices are generally based upon local custom and in his particular area the procedure would have been frowned upon by other physicians.

The best course for physicians to follow on such matters is to check with their County Medical Society before action is taken.

Erythromycin in treatment of abscess

6/21/55

DISCHARGE SUMMARY

On 5/23/55 this patient (colored female, age 24) underwent an excisional biopsy of a breast tumor. On 5/24 tumor was removed and patient discharged from hospital on following day.

On 6/3/55 patient was readmitted because of purulent discharge from wound. On 6/3 a hemolytic Staph. aureus (coag. +) was isolated from abscess with the following disk sensitivities: penicillin, 1.5 units; erythromycin, 10 mcg; tetracycline, 10 mcg. Patient was placed on penicillin, 600,000 units b.i.d. for 10 days. On this schedule patient improved but progress was unsatisfactory and wound continued to discharge small amount of purulent material.

On 6/13 penicillin was discontinued and erythromycin started in dosage of 200 mgm. q.i.d. By 6/17 the discharge had stopped and wound was completely healed by 6/19. Erythromycin was continued until the patient was discharged from hospital on 6/21. Temp. was normal throughout hospital stay.

Final diagnosis: breast abscess due to Staph. aureus.

Result: rapid and complete recovery on erythromycin following failure of penicillin.

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In Memoriam . . .

Rosella Biedermann Boehm, M.D., Jenera ; Woman's Medical College of Pennsylvania, 1923; aged 58; died November 8; member of the Ohio State Medical Association. After completing internship in Pennsylvania, Dr. Boehm took residency work at Louisville Hospital, Ky., and served two years as college physician at Berea College, Ky. She practiced for a number of years in the Hancock-Allen County area. Religious affiliation was with the Lutheran Church. She was married in 1946 to John G. Boehm, who survives. She is also survived by several step-children and a brother.

Harry Bookwalter, M.D., Columbiana; University of Wooster Medical Department, Cleveland, 1900; aged 83; died November 13; member of the Ohio State Medical Association and the American Medical Association; past-president and former vice-president and delegate of the Columbiana County Medical Society and active on a number of local committees. Dr. Bookwalter had been a practicing physician in the Columbiana area for 55 years and had been recognized with the 50-Year Pin and Certificate of the Ohio State Medical Association. He was active in numerous fraternal and civic affairs, including a term as village mayor, and long service on the local board of health. He was a charter member and past-president of the local Kiwanis Club, an official of the Union Banking Company, active in several Masonic bodies, a member of the Presbyterian Church. Survivors include his widow and two sons, one of whom is Dr. H. Lee Bookwalter, also of Columbiana.

Stephen K. Donath, M.D., Toledo; medical degree from the University of Vienna in 1922; aged 55; died November 18; member of the Ohio State Medical Association and the American Medical Association. A native of Hungary, Dr. Donath practiced for approximately 30 years in the Toledo area. During World War II he served as captain in the Army Medical Corps. Dr. Donath was active in a number of fraternal and civic affairs. He served on the local Board of Education, was a former president of the Wernerts Corners Civic Club and Parent-Teacher Association and was active in several Masonic bodies. Surviving are his widow, two sons, his mother and a sister.

Charles J. Haarlammert, M.D., Pleasant Ridge; Miami Medical College, Cincinnati, 1899; aged 82; died November 30; member of the Ohio State Medical Association and the American Medical Association; former vice-president of the Academy of Medicine of Cincinnati. A practicing physician in the Loveland area for more than a half century, Dr. Haarlammert had been honored with the 50-Year Pin of the Ohio State Medical Association. In addition to his practice, he was

active in a number of organizations; was an elder in the Presbyterian Church and a member of several Masonic bodies. He was also a member of the American Legion. Survivors include two daughters, a brother and two sisters.

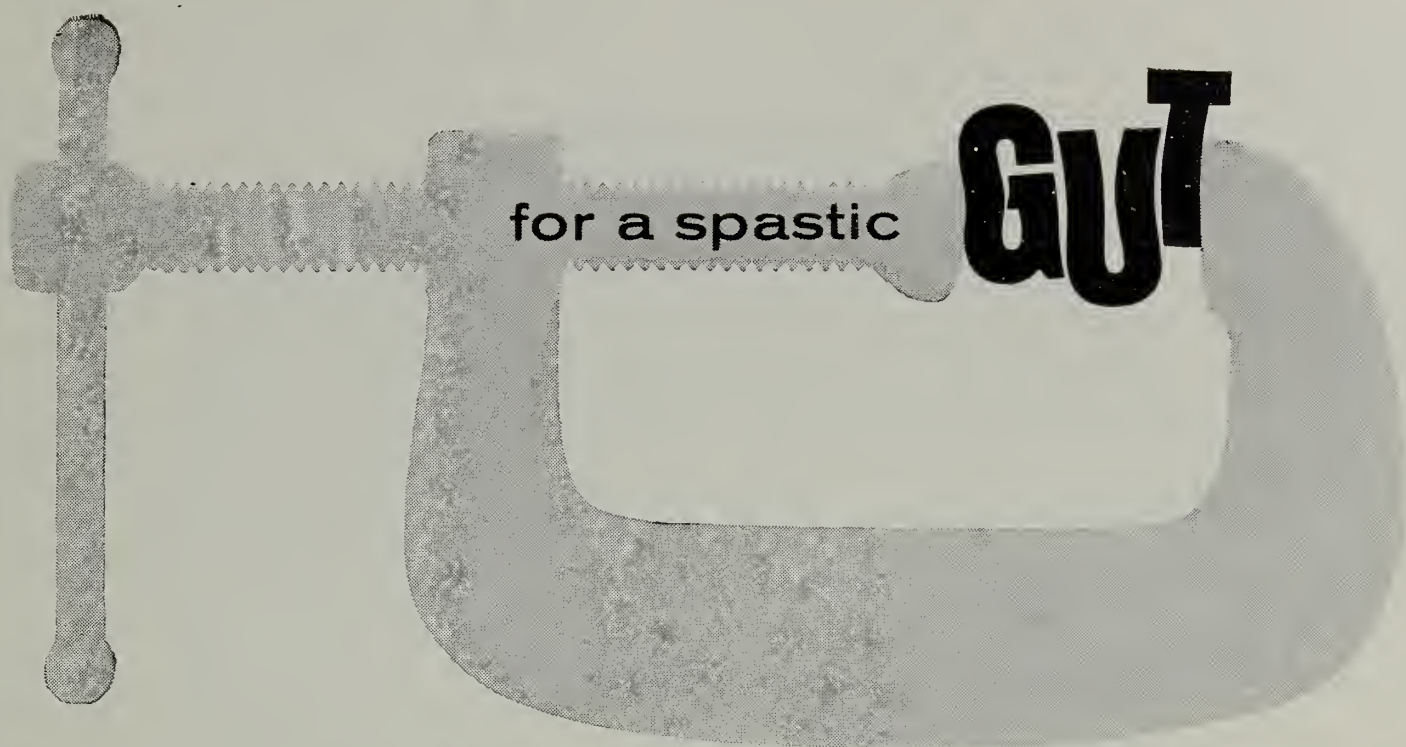
Gustave August Hinnen, M.D., Mt. Lookout (Cincinnati); Miami Medical College, Cincinnati, 1904; aged 75; died November 22; former member of the Ohio State Medical Association, last in 1932. Dr. Hinnen was a practicing physician in the Greater Cincinnati area more than 50 years and had received the 50-Year Pin and Certificate of the Ohio State Medical Association. He was former director of the Cincinnati Zoo and the Museum of Natural History. He leaves two daughters and a brother.

Benjamin M. Kohrman, M.D., Michigan City, Indiana; Ohio State University College of Medicine, 1933; aged 46; died November 26; former member of the Ohio State Medical Association. Dr. Kohrman was a member of the Clermont County Medical Society, 1938-1941 and a member of the Ashtabula County Medical Society 1941-1942. He served with the Army Medical Corps during World War II and set up practice in Indiana about nine years ago. Survivors include his widow, two sons, a brother and four sisters.

Claude F. Love, M.D., Williamsburg; Ohio State University College of Medicine, 1925; aged 59; died November 4; member of the Ohio State Medical Association, and active on several committees of the Clermont County Medical Society. Dr. Love had been a practicing physician in Williamsburg for the past 18 years. He was a veteran of World War I. Surviving are his widow, a son and a stepson.

Robert D. Maddox, M.D., Mt. Auburn (Cincinnati); Medical College of Ohio, Cincinnati, 1900; aged 79; died November 16; member of the Ohio State Medical Association, the American Medical Association, the American Association of Industrial Physicians and Surgeons and Fellow of the American College of Surgeons. A physician over a period of more than a half century, Dr. Maddox's professional career included service during World War I as professor of orthopedic surgery at the Army Medical School in Washington; service with the Veterans Administration and lecturer in military medicine at the University of Cincinnati during World War II. He retired in 1940 with the grade of colonel in the Army Reserve. From 1944 to his retirement in practice in 1951, he was medical director of the Chevrolet and Fisher Body plants in Norwood. Surviving are his widow and a son.

Michael L. Mitchell, M.D., Akron; Western Reserve University School of Medicine, 1924;



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aged 63; died November 13. Dr. Mitchell had recently retired as Lieutenant Colonel after devoting 31 years of service in both military and civil affairs for the U. S. He was a 32nd Degree Mason and belonged to several other organizations. He is survived by his widow, a brother and two sisters.

Samuel Peskind, M. D., Western Reserve University School of Medicine, 1900; aged 77; died November 19; member of the Ohio State Medical Association and the American Medical Association. Born in Russia, Dr. Peskind was brought to this country as a baby. After completing his medical education he was a practicing physician for virtually all of his professional career in Cleveland where he helped found the East 55th Street Hospital with his late uncle and his brother, Dr. Ben Peskind, who survives. He was a member of the Temple.

Wayne S. Ramsey, M. D., Shreveport, La.; Harvard University Medical School, 1912; aged 69; died November 23; member of the Ohio State Medical Association and the American Medical Association. Before his retirement in 1954, Dr. Ramsey was health commissioner of the joint Greenville-Darke County district. He previously served the tri-county district with headquarters in Delaware and before that was connected with the U. S. Public Health Service. He served in the Army Medical Corps during World War I. Surviving are his widow and a son with whom he resided in Shreveport.

Aaron D. Root, M. D., Toledo; Northwest Ohio Medical College, Toledo, 1918; aged 85; died November 14; former member of the Ohio State Medical Association, last in 1928. Dr. Root practiced in Toledo virtually all of his professional career. He retired two years ago.

George Frederick Sykes, M. D., Shaker Heights; University of Ontario Faculty of Medicine, 1917; aged 63; died December 5; member of the Ohio State Medical Association, the American Medical Association and the American Association of Industrial Physicians and Surgeons; former delegate of the Academy of Medicine of Cleveland. Dr. Sykes was medical director for the White Motor Company from 1922 until his recent retirement. He was a veteran of World War I, having served with the Canadian Army Medical Corps. Survivors are his widow, a son, a daughter and a brother.

Cloyd Franks Wharton, M. D., Akron; Ohio State University College of Medicine, 1914; aged 67; died December 2. Dr. Wharton had been a practicing physician in Akron for 37 years. He was a veteran of World War I, a member of the American Legion, and had served three terms on the Akron police pension board. He is survived by his widow, two daughters and a son.

Licensed Through Endorsement by State Medical Board

The State Medical Board of Ohio has issued licenses to practice medicine and surgery in the State to the following physicians through endorsement of their licenses to practice in other states, or certification by the National Board of Medical Examiners (included are intended residence and medical school of graduation):

August, 1955—William M. Lordi, Columbus, Long Island College.

October 4, 1955—Salo Albini, University of Iasi, Rumania; Robert H. Baxter, Akron, Loyola University; John H. Bechtel, Cincinnati, Boston University; Basil V. Bisca, Columbus, New York Medical College; Lewis F. Bissell, Hudson, University of Arkansas; Richard D. Burk, Columbus, Creighton University;

Floyd W. Denny, Jr., Cleveland, Vanderbilt; Carl K. Dvorschak, Wellington, Marquette; Danny Glassman, Rush Medical College; Harry Goldblatt, Cleveland, McGill University; Walter A. Griesbach, Chicago Medical School;

Irwin B. Hanenson, Cincinnati, New York University; James B. Hutchison, Cleveland, Queen's University, Canada; Irving Igdaloff, Toledo, Chicago Medical School; Francis J. Januszkeski, Shaker Heights, University of Maryland; Robert W. Jones, Cleveland, Temple University;

William H. Keeler, III, Dayton, Temple; Raymond R. Klika, Cleveland, George Washington University; Hilda Knobloch, Columbus, New York University; Gordon R. Loomis, Cleveland, St. Louis University; Herman M. Lubens, Columbus, University of Berlin;

Edward C. McGarry, Dayton, George Washington University; Roary A. Murchison, Athens, University of Louisville; Gerald F. Nagle, Dayton, University of Maryland; Sheldon R. Newcomer, University of Michigan; Vol K. Philips, Columbus, Washington University; George J. Prochnow, Kent, Northwestern;

Martin K. Rosenbaum, Gallipolis, Yale; Barton T. Smith, Toledo, University of Nebraska; Hans J. Sowka, University of Heidelberg; Robert M. Sturman, Cleveland, New York University;

John R. Tarr, Minerva, University of Pittsburgh; Grace F. Thomas, Canton, University of Southern California; James C. Trivett, Bay Village, Medical College of Virginia; Robert J. Walker, Jr., Hamilton, Medical College of Virginia.

Dr. Harry Goldblatt, professor of experimental pathology at Western Reserve University, will be the sixth annual speaker in the Phi Delta Epsilon Medical Fraternity guest lectureship series. He will speak on Wednesday, February 1, at 8 p. m., in the conference theater of the Ohio Union on the OSU Campus in Columbus. The subject will be "Recent Advances in Cancer Research." Members of the medical profession and their guests are invited.

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First District

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MIDDLETOWN)

CLERMONT

Dr. Thomas Longworth, of Felicity, was honored with the 50-Year Pin and Certificate of the Ohio State Medical Society at the November 16 meeting of the Clermont County Medical Society held in Felicity.

CLINTON

"Dr. Robert Conard, Clinton County health commissioner, practicing physician in Wilmington for 24 years, with a long and distinguished career in the Army and with Selective Service, was honored by the Ohio State Medical Association and the Clinton County Medical Society at a dinner at Snow Hill Country Club Wednesday night (December 7)."

The above paragraph is the lead of a feature article which appeared with Dr. Conard's picture in the *Wilmington News Journal* the following day. The article continues by relating that Dr. Conard was presented a certificate and pin from the Ohio State Medical Association for 50 years of service as a physician at the party given by the County Medical Society. Mrs. Conard and other wives of doctors were present.

Dr. Richard R. Buchanan, as president of the Society, presided at the program and presented the certificate and pin. Dr. Kelley Hale, Dr. V. E. Hutchens, Dr. W. J. Trainor, Wilmington, and Dr. John Anderson, of Lynchburg, spoke briefly.

Following service in the Army during the Spanish American War, Dr. Conard entered the Medical College of Ohio and was graduated in 1905, then took internship at St. Elizabeth Hospital, Dayton. He began practice in Blanchester in 1906 and in 1907 married Miss Margaret Thompson. He served in the Army from 1917 to 1919, was regimental surgeon and held the rank of major. From 1919 to 1921 he again practiced in Blanchester and then once more did Army work, serving as superintendent of the Ft. Leavenworth, Kans., Hospital. In 1926 he returned to private practice and moved to Wilmington where he continued in practice for 24 years.

Through World War II he headed the state procurement service while carrying on his practice and during the Korean Conflict headed the Military Advisory Committee of the OSMA. After living in retirement for two years, Dr. Conard accepted the post as Clinton County health commissioner.

In the business session at the same meeting Dr. Arthur F. Lippert was elected president to

succeed Dr. Buchanan; Dr. Nathan Hale was elected vice-president and Dr. David Hamilton, secretary-treasurer.

HAMILTON

Programs presented by the Academy of Medicine of Cincinnati during December included the following features:

December 6—"Some Recent Advances in Clinical Endocrinology," Dr. E. Perry McCullagh, Cleveland Clinic.

December 20—A Symposium on "Newer Antibiotics," Dr. Harry F. Dowling, professor and head of the Department of Medicine, University of Illinois; and Dr. William A. Altemeier, professor and director of the Department of Surgery, University of Cincinnati and Cincinnati General Hospital.

Scheduled for January 17 is a symposium on "Painful Joints," with the following speakers: Dr. Joseph Lee Hollander, associate professor of medicine, University of Pennsylvania, and Dr. William D. Robinson, professor of internal medicine, University of Michigan, and consultant at the Rackham Arthritis Research Unit of the University.

Second District

(COUNCILOR: G. A. WOODHOUSE, M. D.,
PLEASANT HILL)

CLARK

Dr. Frank W. Anzinger, Jr., 1956 president-elect, was installed as president of the Clark County Medical Society November 22, succeeding Dr. C. W. Hullinger.

At the same meeting, election of officers was conducted, with the following results:

President-elect for 1957—Dr. John D. LeFevre; secretary—Dr. Charles E. Fralich; treasurer—Dr. George P. Fitzgerald, Jr.; delegates to Ohio State Medical Association—Dr. R. M. Turner and Dr. J. Harold Shanklin; alternates—Dr. William H. Crays and Dr. E. W. Schilke.

In his inaugural remarks, Dr. Anzinger stated that the society's 1956 program should include increased activities in two fields. He defined the first field as public relations and the second field as state and national legislative matters of interest to members of the medical profession.

A history of the Clark County Medical Society, covering the period of 1815 to 1955, has been compiled by Dr. D. J. Parsons and is expected to be published in January, it was reported at the November session.

Members attending the meeting heard a representative of the Medical Protective Co., Fort Wayne, Ind., speak on "Medical Prophylaxis."

In lieu of the regular December meeting, the Woman's Auxiliary of the society and wives of

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*Schaefer, F. H.: Ohio State M. J. 51:347 (April) 1955.

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society members scheduled their annual Christmas party for physicians at the Springfield Country Club December 21.

Another December activity involved an organizational meeting of new officers and others conducted by Dr. Anzinger in preparation for 1956 programming and activities.

DARKE

The regular dinner meeting of the Darke County Medical Society was held at the James Hotel in Greenville on November 15. Dr. H. A. Nieman, Dayton, was guest speaker for the occasion and discussed "Dermatology."

Third District

(COUNCILOR: JAMES R. JARVIS, M. D., VAN WERT)

CRAWFORD

Doctors and lawyers of Crawford County met on November 2 at Greenlawn Restaurant, east of Bucyrus, in a joint dinner session. Purpose of the meeting was to discuss some of their mutual problems. There were 54 persons present.

Speakers for the meeting were Robert L. Ross, Mansfield attorney, who talked on the subject, "Doctors as Expert Witnesses," and Clarence F. Purdy, Bucyrus attorney, whose talk was entitled "Preparation of Medical Statements."

Fourth District

(COUNCILOR: PAUL F. ORR, M. D., PERRYSBURG)

HENRY

The Henry County Medical Society met on December 6 at Holgate. Following dinner at the Hotel Holgate, talks were made by Dr. Paul F. Orr, Perrysburg, Fourth District Councilor, and Dr. John F. Hillabrand, Toledo, member of the State Committee on Maternal Health.

The following officers were elected for 1956: President, Dr. Bernard J. George, Liberty Center; Secretary-Treasurer, Dr. Thomas F. Tabler, Holgate; Delegate, Dr. Tabler; Alternate delegate, Dr. Edwin C. Winzeler, Napoleon.

LUCAS

The Inter-Hospital Postgraduate Lecture Series presented by the Medical Advancement Trust of the Maumee Valley Hospital was presented at the Academy of Medicine Building in Toledo on December 8 and 9.

Speaker for the occasion, the 28th inter-hospital series, was Dr. Robert B. Greenblatt, professor of endocrinology, Medical College of Georgia. His theme for the series was "Clinical Endocrinology—Newer Concepts in Management of Endocrine Disorders." Subjects discussed included, hypoovarianism, functional uterine bleeding—the menopause, menstrual distress, endocrine aspects of infertility, disorders in the sexual sphere, uses and abuses of endocrines in general practice.

WOOD

On December 15, the Wood County Medical Society and the Auxiliary held a joint dinner meeting at Midway Restaurant. A musical program was given under direction of Dr. J. P. Kennedy, head of the Music Department of Bowling Green State University.

Fifth District

(COUNCILOR: GEORGE W. PETZNICK, M. D., CLEVELAND)

CUYAHOGA

The Academy of Medicine of Cleveland honored seven physicians of the Cleveland area, four of them in absentia, for a half-century of service in the medical profession, at its November 19 meeting.

Present to receive the awards were Dr. Ernest H. Cox, Chagrin Falls; Dr. Shandor H. Monson, Shaker Heights; and Dr. Aretas E. Biddinger, Cleveland Heights. Honored in absentia were Dr. Otto L. Goehle, Rocky River; Dr. Philip A. Jacobs, Cleveland Heights; Dr. Newton S. Banker, Bratenahl; and Dr. Richard Dexter, Shaker Heights.

Dr. George W. Petznick, Councilor of the Fifth District, made the presentations of the Ohio State Medical Association's 50-Year Pins and Certificates.

The ceremony preceded the annual Lower Lecture which was presented by Dr. Michael E. DeBakey, professor of surgery at Baylor University, who discussed blood vessel surgery.

Sixth District

(COUNCILOR: CARL A. GUSTAFSON, M. D., YOUNGSTOWN)

MAHONING

Dr. Robert F. Bradley, of Boston, was in Youngstown on November 15 for a series of clinics and meetings in connection with Diabetes Detection Week. Mahoning County Medical Society members conducted a county-wide diabetes detection drive with Dr. Morris S. Rosenblum as chairman.

Dr. Bradley conducted a clinic at St. Elizabeth Hospital beginning before noon. In the afternoon he spoke before the staffs of all local hospitals at North Side Hospital on the subject, "Liver Disease and Diabetes."

He was a dinner guest of the Society in the Elks Club and in the evening spoke on the subject, "Coronary Heart Disease in the Diabetic."

Associated with Dr. Rosenblum in observance of "Diabetes Detection Week" were the following physicians: Drs. Milton M. Yarmy, Herman I. Ipp, G. E. DeCicco, Kenneth J. Hovanic, Lewis K. Reed, Alexander Calder, C. F. Wagner, J. B. Stechschulte, E. J. Wenaas, Frederick S. Coombs,

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On Thursday and Friday of the same week Youngstown district residents were invited to attend an exhibit on diabetes at North Side Hospital under direction of the County Society. The exhibit included movies, a picture display of proper foods for diabetics and other material. Physicians and nurses were present to answer questions.

It was announced in the public press that free urine examinations would be given during the week at the office of any member of the Society or at the hospital laboratories.

STARK

Dr. Claude Beck and Dr. Bernard Brofman, both of Western Reserve University School of Medicine, were guest speakers at the November 10 meeting of the Stark County Medical Society. The evening meeting was held in the Belden Hotel, Canton. Subject for discussion was, "Revascularization of the Heart."

Seventh District

(COUNCILOR: ROBERT HOPKINS, M. D.,
COSHOCTON)

BELMONT

A dinner meeting was held at the Belmont Hills Country Club on November 17 with members of the Belmont County Medical Society and Auxiliary attending. Speaker for the occasion was Dr. E. V. Arbaugh, Jr., who discussed "Current Opinions on Controversial Surgical Procedures."

Eighth District

(COUNCILOR: ROBERT S. MARTIN, M. D., ZANESVILLE)

GUERNSEY

The Guernsey County Medical Society met on November 3 at the Berwick Hotel in Cambridge with 23 members and one guest present. The meeting was conducted by Dr. Thomas Frame, vice-president, who introduced Dr. Charles Wehr, of Zanesville as guest speaker, who discussed the use of bronchograms in the diagnosis of pulmonary diseases.

Dr. Henry L. Wells, Cambridge, was honored at the December 1 meeting when he was presented the 50-Year Pin and Certificate of the Ohio State Medical Association. Dr. Robert S. Martin, Zanesville, Councilor of the Eighth District, presented the awards in behalf of the Association.

MUSKINGUM

Dr. Harry A. Martin, Gratiot, a member of the Muskingum County Medical Society although he resides just across the border of the county, was honored with the 50-Year Pin of the Ohio State Medical Association on December 1. Because of illness Dr. Martin was not able to attend

a meeting of the Society, and Dr. Robert S. Martin, Zanesville, Councilor of the Eighth District, made the presentation in his home.

Tenth District

(COUNCILOR: E. H. ARTMAN, M. D., CHILLICOTHE)

FRANKLIN

Dr. Karl E. Paschkis, associate professor of medicine and associate professor of physiology and director of the Division of Endocrine and Cancer Research at Jefferson Medical College of Philadelphia, was guest speaker at the November 21 meeting of the Columbus Academy of Medicine. His subject was "Problems of Abnormal Sexual Development and Function in Clinical Practice."

Eleventh District

(COUNCILOR: H. T. PEASE, M. D., WADSWORTH)

LORAIN

The regular monthly meeting of the Lorain County Medical Society was held on November 8 at the Spring Valley Country Club, Elyria, beginning with dinner.

An address, "Modern Treatment of Hypertensive Vascular Disease," was given by Dr. Robert Stahl, Cleveland. Following a business meeting, a memorial address for the late Dr. Schurgot was given by Dr. Roy Hayes.



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President—Mrs. Karl F. Ritter, 1420 Shawnee Road, Lima
President-Elect—Mrs. William H. Evans, 291 Park Ave., Youngstown

Vice-President—Mrs. W. R. Gibson, 201 E. Water Street, Oak Harbor

Recording Secretary—Mrs. S. L. Meltzer, 2442 Dorman Drive, Portsmouth

Corresponding Secretary—Mrs. J. M. McBride, 808 Pears Ave., Lima

Treasurer—Mrs. Herbert Van Epps, 425 E. 15th St., Dover

Past-President—Mrs. A. Paul Hancuff, 3551 Maxwell Road, Toledo

LUCAS

One of the projects of the Woman's Auxiliary to the Academy of Medicine of Toledo and Lucas County is interesting high school age girls in nursing careers. Mrs. Brian Bradford and Mrs. Robert B. Walker entertained at a fund-raising party for nurse recruitment in Mrs. Bradford's home.

Annually the auxiliary sponsors a tea for the prospective nurses. Efforts also are made to form future nurses clubs among interested girls. The auxiliary continues its interest even after girls decide to enter training through scholarships. Each year a three-year scholarship is awarded to a student nurse. The scholarship is rotated among the Toledo hospitals. This year the award will go for training at Mercy Hospital.

Mrs. Ned B. Hein is chairman of the nurse recruitment committee, which includes Mrs. C. Lewis Stevers, co-chairman; Mrs. Jack C. Burnheimer, Mrs. A. James Blanchard, Mrs. Charles F. Jones, Mrs. Arthur P. James, Mrs. J. Hugh Webb, Mrs. George Bates, Mrs. I. W. McConnell, Mrs. Paul Baehren, Mrs. A. A. Brindley, Mrs. Fred M. Douglass and Mrs. Paul L. Bell.

The auxiliary social activities chairman, Mrs. E. L. Gaspari, was hostess for coffee. Among those attending were Mrs. C. J. A. Paule, president, Mrs. W. Leroy Bryant, program chairman, Mrs. John D. Dickie, who headed the social activities committee last year and Mrs. Woodward, publicity chairman. Mrs. Carl A. Breyer is Mrs. Gaspari's co-chairman.

The fund raising committee of the Woman's Auxiliary to the Academy of Medicine of Toledo and Lucas County sponsored a dessert bridge party at the home of Mrs. John B. Rank. Mrs. Willys L. Woodward was co-hostess with Mrs. Rank.

The Woman's Auxiliary to the Academy of Medicine scheduled several meetings for October. The first general meeting of the season was October 18 in the Academy Building. Mr. and Mrs. Edward Packer presented slides illustrating their talk, "To The Farm East by Freight," including Japan, Korea, Ceylon, India and

Malaya. Mrs. W. Leroy Bryant is program chairman and Mrs. Frank T. LoFiego reservations chairman.

The Live Issues of Today Evening Group met with Mrs. Jack Mills, 2509 Meadowwood Road. The Guild Development Study Group met October 21 in the home of Mrs. Robert R. Willard.

The English Study Group meets every Monday at 1 P. M. in the Academy Building. This course consists of 15 lessons led by Harry Ross.

The Leadership Training and Public Speaking Study Group met in the Academy Building October 21. The Musicale Masqueraders, choral group of the Auxiliary, met in the Hope Lutheran Church.

The community chest team of the auxiliary held report meetings October 11 and 18 at the Academy Building.

The Musicale Masqueraders choral group entertained at a recognition breakfast for all the volunteer workers in the Citizens Day Care program.

The Toledo and Lucas County Auxiliary is one of the sponsors of the Volunteer Citizens Day Care for school children. It helps with the program in time, financial ways and gifts.

MAHONING

The Auxiliary to the Mahoning County Medical Society had their first meeting in the form of a lawn party and dessert bridge at the home of Mrs. Raymond Lupse. Mrs. Craig Wales, the new president, presided.

The Auxiliary held a guest day and style show at the Calvin Center October 18 as one of the eight "very special" sessions of the year, the organization's fifteenth.

Mrs. Craig C. Wales is this year's president, her associate officers including Mrs. J. J. Wasilko, vice-president, Mrs. John A. Renner, recording secretary, Mrs. Frederick S. Coombs, Jr., recording secretary, and Mrs. Ben S. Brown, treasurer. Mrs. Ivan C. Smith is immediate past-president and Mrs. Paul J. Mahar, is president-elect. Mrs. Edward A. Shorten is chairman of the program committee and Mrs. Frank K. Inui is her co-chairman.

In addition to 198 active members, the organization has seven nonresident members, 16 junior active members, 42 hospital intern members and nine honorary members.

Another highlight of the pre-Winter months was the nurses' scholarship fund dance on November 12 at the Sugar Creek Country Club. Marking the first program for the new year will be the January 17 dinner at which Mrs. Esther Stuhlfire will be guest speaker, her topic being "The Florence Crittenton Home." St. Elizabeth Hospital will be the scene of a tea for prospective

nurses on February 21. The program will feature Mrs. Ethel M. Hopkins, director of nursing education at St. Elizabeth's, as speaker.

The style show and tea sponsored by the Woman's Auxiliary to the Mahoning County Medical Society was held at the Calvin Center, at which 400 women saw a display of the new autumn fashions as presented by McKelvey's. Mrs. Craig Wales, president, introduced Mrs. Edward Bauman, president of the Trumbull County Auxiliary, who urged all local Auxiliary members to attend the Sixth District Postgraduate Day in Warren. Mrs. Cary Peabody reported for the legislative committee, and announcement was made of the annual dance for the benefit of the Auxiliary nurses' scholarship fund to be held November 12 at Sugar Creek Country Club.

MARION

Officers were installed and club pins presented to Harding and St. Mary High School senior girls, members of the Future Nurses Clubs, in a ceremony October 20 at Marion General Hospital. The Clubs, organized last spring, are sponsored by the Auxiliary to the Marion Academy of Medicine. Presidents of the student groups are Kathleen Kelly of St. Marys Club and Pat Matthews at Harding.

Members of the auxiliary school faculties and parents of the club members comprised the audience of approximately 100 persons. The Very Rev. William J. Spickerman, pastor of St. Mary Catholic Church, delivered the invocation and greetings were extended by Mrs. Frank C. Vogt of the auxiliary.

OTTAWA

Mrs. A. D. Miessner entertained the Auxiliary of the Ottawa County Medical Society in her Catawba Cliffs home. During the business meeting a report was given on the rummage sale. A discussion was also held on the Fourth District conference in Bowling Green. The group also discussed the credits and awards as regulated by the State organization. The program of the year was read and approved.

Following the business meeting doctors joined their wives for a social hour and refreshments were served by the hostess.

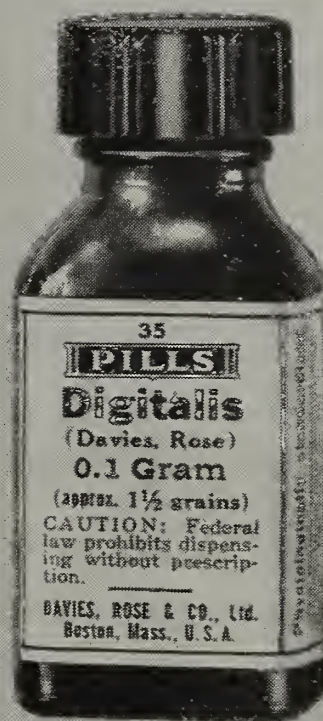
MIAMI

Mrs. Karl F. Ritter, of Lima, state president of the Ohio Medical Auxiliary, was guest speaker when the Miami County Auxiliary met for lunch and a business session at the Stouder Memorial Hospital, Troy. Mrs. Ritter described work being done by the organization and explained the mechanics of the state society.

Members of the Miami County Medical Society Auxiliary were hostesses November 1 at the Altrurian Club house in Troy to a tea for girls interested in the nursing profession. Fifty-seven girls accepted the invitation, 27 of whom

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Guest speaker was Mrs. Marjorie Fawcett of Dayton, president of the Tenth District Ohio State Nurses Association.

RICHLAND

George Headley, executive secretary of the Richland County Child Welfare Board, was the guest speaker at the Woman's Auxiliary to the Richland County Medical Society meeting. His talk followed a luncheon at the Women's Club. He was introduced by Mrs. Paul Lee, Chairman. "Mental Health of Richland County Children" was the subject of the speaker.

Mrs. Robert Peirce, president, conducted the business session. Mrs. F. M. Wadsworth, organization chairman, introduced Mrs. Marvin Dees and Mrs. Forest Freeman as new members and Mrs. Joann Secrist as a guest. Fifty-three members were present.

A silent auction was held for the benefit of the American Medical Education Foundation with Mrs. Wendell Bell in charge. Hostesses for the day were Mrs. R. E. Frush, Mrs. L. A. Hautzenroeder, Mrs. Max Brown, and Mrs. J. M. Garber.

ROSS

Woman's Auxiliary to the Ross County Academy of Medicine voted to lend \$200 to a Chillicothe girl interested in nursing at a special meeting. The president, Mrs. Robert P. Giesler, was hostess to the group at her home. The \$200 will come from a fund established by the auxiliary and is to be repaid after the girl finishes her studies and obtains a nursing position.

Mrs. Howard Wood, chairman of the committee for radio-visual education, reported on exhibits for the Ross County Fair. The club voted to sponsor a booth concerning home accident prevention.

Members of the Auxiliary and Hospital Guild 1 met for sewing at the home of Mrs. David McKell. Under the direction of Mrs. Lewis Coppel part of the group made safety flags of blue and yellow cloth to be given to the six grade schools in the city for use as safety awards. It was noted that several auxiliaries in the state had worked on similar projects.

The remainder of the group made six dozen towels for Chillicothe Hospital, with Mrs. Paul McCarter, vice-chairman of the guild, in charge of the work. Following the sewing Mrs. McKell served tea.

SANDUSKY

The auxiliary to the Sandusky County Medical Society held a meeting at the home of Mrs. R. R. Wilson with Mrs. M. S. Huber, the president, in charge of the business meeting.

The group voted to send the magazine *Today's Health* to the county high schools.

Mrs. A. F. Schultz was honored as being the only member with a perfect attendance at

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1. McLester and Darby: "Nutrition and Diet in Health and Disease," ed. 6, Saunders, p. 195. 2. McCay, C. M., in Lansing: "Problems of Aging," ed. 3, Williams and Wilkins, 1952, p. 193. 3. Sebrell and Hundley, in Stieglitz: "Geriatric Medicine," ed 3, Lippincott, 1954, p. 189.

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meetings for the year. The legislation chairman, Mrs. F. A. Visconi, gave a report on sample ballots for the November 8 election.

A social hour followed. The tea table was beautifully arranged with fall flowers. Mrs. Huber poured. Hostesses were Mrs. J. L. Curtin, Mrs. W. J. Martin and Mrs. Wilson.

SHELBY

Woman's Auxiliary to the Shelby County Medical Society spent an afternoon of work and discussion when the October meeting was held in the home of Mrs. E. P. Sparks, Jr. on Port Jefferson Road. The work was the making of cellulose pads for the benefit of cancer patients in Wilson Memorial Hospital. It was continued both through the business and the social hours.

The group went on record as unanimously approving the issue to come before the voters at the November election concerning the bond issue to supply mental hospitals, public schools, state universities and colleges.

It voted to continue the project of supplying Wilson Memorial Hospital with eight copies of the *Dayton Daily News* each Sunday. The meeting opened with a dessert course preceding the business hour.

Mrs. Alice Costolo explained issues to be voted upon at the general election.

Money-making projects were discussed to establish the funds needed to carry through the projects of the auxiliary, including the material for making the cancer pads. Mrs. Sparks, president-elect, took over the business meeting in the absence of the president, Mrs. J. F. Conner.

SCIOTO

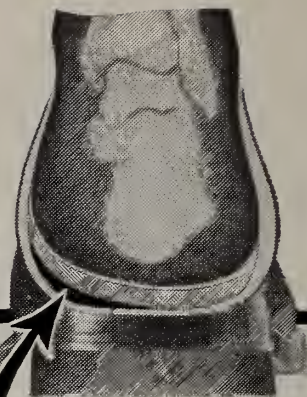
Mrs. Karl Ritter of Lima, president of the Woman's Auxiliary to the Ohio State Medical Association, stressed "Individual Responsibility" as a slogan for each member when she appeared as guest speaker at the combination meeting of the Woman's Auxiliary of Scioto County Medical Society and the Ninth District. Mrs. Ritter explained that this slogan carries out the National theme of the organization, "Active Leadership in Community Health."

Since the local auxiliary was founded in 1940, the same year as the founding of the state auxiliary, its 15th anniversary was celebrated at this combination meeting at Harold's.

A crystal theme prevailed. Flowers and silver and white place cards bearing a "15" decorated the luncheon tables. The invocation was offered by Mrs. C. W. Wendelken.

For the dessert each member was served a piece of cake bedecked with a "15" and Mrs. B. U. Howland, president of the local auxiliary and director of the Ninth District, presented Sister Titus and the Mercy Hospital Glee Club, who sang "Happy Birthday" in honor of the charter members. Mrs. S. L. Meltzer, first president of the

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GYNECOLOGY—Office & Operative Gynecology, two weeks, Feb. 13, March 12. Vaginal Approach to Pelvic Surgery, one week, Feb. 6, March 5.

OBSTETRICS—General & Surgical Obstetrics, two weeks, Feb. 27, March 26.

MEDICINE—Internal Medicine, two weeks, May 7. Electrocardiography & Heart Disease, Two Week Basic Course, March 12. Gastroscopy, Forty-Hour Course, March 19. Dermatology, two weeks, May 7.

RADIOLOGY—Diagnostic X-Ray, two weeks, Feb. 6, April 30. Clinical Use of Radioactive Iodine, one week, April 2. Clinical Uses of Radioisotopes, two weeks, May 7.

PEDIATRICS—Intensive Review Course, two weeks, May 14. Neurological Diseases: Cerebral Palsy, two weeks, June 18.

UROLOGY—Two-Week Course, April 16. Cystoscopy, ten days, by appointment.

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Edward J. Stieglitz, M.D.

CONSTRUCTIVE MEDICINE IN AGING: EMOTIONAL MATURITY

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Auxiliary and present secretary of the state organization, also was honored with a song.

Another highlight of the program was a talk by Dr. Carter L. Pitcher, Councilor of the Ninth District and auxiliary adviser, who explained the duties of the advisory council. Dr. Pitcher urged auxiliary members to contribute to the American Medical Education Foundation.

Other guests were Mrs. Shelley Strain, president of the Pike County auxiliary; Mrs. G. N. Spears, president of the Lawrence County auxiliary; Mrs. Barney Osborne, Mrs. Ralph Massie, Mrs. Charles Gallagher, Mrs. Kenneth Mahle, Mrs. Harry Nennin of Ironton, Ohio and Mrs. James G. Murtin of Philadelphia.

Paintings by Mrs. Wendelken were on display.

Hostesses were members of the executive board: Mrs. Howland, Mrs. William C. Hugenberg, Mrs. Wendelken, Mrs. R. B. Rardin, Mrs. Jerome Sheets, Mrs. Joseph T. Gohmann and Mrs. A. P. Hunt.

SUMMIT

The Woman's Auxiliary of the Summit County Medical Society had their first luncheon meeting of the 1955-1956 season at the Fairlawn Country Club.

Mrs. L. M. Weinberger, president, presided and Mrs. R. R. Plislen, program chairman, introduced Dr. Warren A. Guthrie, well-known television news analyst.

Dr. Guthrie, whose topic was "Is Anybody Listening?," is head of the department of speech at Western Reserve University. Members were urged to bring guests. The annual membership tea of the Woman's Auxiliary to the Summit County Medical Society was held at the home of Dr. and Mrs. Laurence M. Weinberger. Mrs. H. S. Senne and Mrs. R. B. Smith, chairman of the social committee, assisted in planning the party with the following committee members: Mrs. T. V. Berlinger, Mrs. R. G. McCready, Mrs. R. B. Sommerfield, Mrs. R. R. Zeno, Mrs. C. T. Korsmo, and Mrs. D. J. Roberts. As chairman of the Hospitality Committee Mrs. L. M. Walker greeted members assisted by Mrs. E. W. Grubb, Mrs. William Davis and Mrs. William Fairweather.

Summit County Medical Society held an outing at the Fairlawn Country Club for members and wives followed by a dinner dance at the University Club. Dr. Donald M. Traul was general chairman. Dr. Rankin was chairman of the men's golf committee and Mrs. Traul for the women. The Auxiliary to Summit County Medical Society, of which Mrs. Laurence M. Weinberger is president, had charge of decorating the ballroom for the dance.

A committee from the Woman's Auxiliary, headed by Mrs. Edwin Mallin, was in charge of the Hobby Show for Oldsters held in Akron in O'Neils auditorium. Mrs. Laurence Weinberger

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VAN WERT

The Van Wert County Medical Auxiliary met October 4 in the home of Mrs. Jack Cox. The group voted to continue to maintain the Babies Auxiliary project at the Van Wert County Hospital. To date 550 babies have joined the Auxiliary. The proceeds from the project are used for needed equipment for the hospital nursery.

WASHINGTON

Pictures of Boulder Dam, Disneyland, and The Trip of the Sternwheeler, W. P. Snyder, down the Ohio to its new dock in Marietta, highlighted the dinner meeting October 19 of the Woman's Auxiliary to the Washington County Medical Society in the Rufus Putnam Room at Hotel Lafayette. Mrs. Richard Hille and Mrs. Don Fleming of Vincent were in charge of arrangements.

The program was presented by S. D. Hoag. He gave an explanation for the need of Boulder Dam and illustrated its benefits to the area. Mrs. Fleming, president, introduced guests, Mrs. A. A. Coulson of McConnellsville and Mrs. Henry Bachman of Malta, members-at-large.

A report was given on progress of the nurses tea scheduled for November 2 at Memorial Hospital. This tea is an annual event open to all junior and senior girls of the local and Washington County schools. Mrs. Edgar Northrup and Mrs. Clarence Ash were named program chairmen and Mrs. Eddy, Mrs. Deane Northrup and Mrs. E. W. Hill, Jr., the dining room committee. Mrs. Eddy announced the workers for the rummage sale and Mrs. Hill reported on the group conferences she attended in Columbus.

(Editor's Note: Additional Woman's Auxiliary notes submitted for January will be published in a subsequent issue, because of limited space.)

The Southwestern Ohio Society of General Physicians in cooperation with the University of Cincinnati College of Medicine, recently presented a series of four Thursday programs on "Advances in General Medicine."



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Dr. Forman Attends Watershed Meetings in Washington

Dr. Jonathan Forman, Editor of *The Journal*, attended the Second National Watershed Congress in Washington, D. C., where he represented as president of the Friends of the Land one of the 20 sponsoring organizations.

He also attended the Conservation Council meeting and the directors meeting of the United Conservation Fund. He was invited by the staff to have luncheon at the White House and present his personal views on upstream soil conservation practices and flood prevention, especially his opposition to the Hoover Commission's proposal to give all water conservation to the U. S. Army Corps of Engineers, thus taking the upstream engineering and soil practices out of the hands of the Department of Agriculture Soil Conservation Service.

Other activities of the Editor during December included an address before the Franklin County Association of Methodist Ministers on "The Role of the Minister in Healing the Sick."

He also was reelected president of the Ohio Children's Society, an organization for the care of and placing of children.

Another Low in Mortality Rate Seen for 1955

The death rate for 1955—9.2 per 1,000 of population in the United States—will be about equal to that of 1954, the lowest on record, according to statisticians of the Metropolitan Life Insurance Company, who base their statement on the experience so far this year. Furthermore, it is stated, the outlook for 1956 is also very favorable.

This marks the eighth successive year for which the death rate for the country has been below 10 per 1,000 population.

A notable feature of the 1955 record is another substantial reduction in mortality from tuberculosis. For the first time the death rate from this disease will have been somewhat less than 10 per 100,000 of the population.

Mortality from influenza and pneumonia continued at a low level in 1955. Although there have been outbreaks of influenza within the last decade, the general trend of mortality has been sharply downward.

In 1955 there were about 29,000 cases of poliomyelitis in the country, compared with about 39,000 for the year before. For most of 1955 the weekly incidence of the disease was below that for 1954. The margin between the two was most appreciable during the summer and early fall months, the period of the year when the incidence of the disease mounts rapidly.

The combined death rate from communicable diseases of childhood was under 1 per 100,000 population during the year.

INDEX TO ADVERTISERS

Abbott Laboratories	86 - 87
American Meat Institute	8
Ann Arbor School	16
Appalachian Hall	16
Ayerst Laboratories, Inc.	91
Bayer Company, The, Div. of Sterling Drug Co., Inc.	3
Burroughs Wellcome & Co. (U. S. A.) Inc.	15
Chicago Medical Society	95
Ciba Pharmaceutical Products, Inc.	89
Cincinnati Sanitarium	19
Cook County Graduate School of Medicine	102
Davies, Rose & Co., Ltd	99
Dearborn Inn	96
Endo Products, Inc.	81
Fazio, Thomas, Laboratories (Surgical Appliance Division)	107
Foot-so-Port Shoe Co.	102
General Foods Corporation (Sanka)	6
Harding Sanitarium	20
Hoffmann-LaRoche, Inc.	Insert between pages 16 - 17
Knox Gelatine Co., Inc.	97
Lakeside Laboratories, Inc.	1
Lederle Laboratories	58 - 59
Liebel-Flarsheim Co.	14
Lilly, Eli, and Company	24
Luzier's, Inc.	89
MacAllister Laboratory	105
Maico of Columbus	105
McMillen Sanitarium	20
Mead Johnson & Company	Back Cover
Medical Protective Company	104
Merrell, Wm. S., Co.	103
Neil Training School	107
New York Polyclinic Medical School	83
Oak Ridge Sanatorium	19
Parke, Davis & Company	108 and Inside Back Cover
Pfizer Laboratories, Division, Chas. Pfizer & Co., Inc.	5, 79, 93
Picker X-Ray Corporation	21
Pogue, Mary, School, Inc.	105
Quincy X-Ray & Radium Lab.	105
Rocky Glen Sanatorium	95
Sawyer Sanatorium	18
Schering Corporation	9, 22 - 23
Scroggins, Clayton L., Associates (Medical-Dental Management)	91
Searle, G. D. & Company	73
Sharp & Dohme, Inc.	13
Smith, Kline & French Laboratories	75
Squibb, E. R. & Sons, Division of Olin- Mathieson Chemical Corporation	7
Stoneman Press	101
Tutag, S. J. & Company	101
Upjohn Company	17, 83
Vitamin Food Co., Inc.	100
Wendt-Bristol Company	104
Wesnoca	107
Wickhaven Sanitarium	74
Windsor Hospital, Inc.	95
Winthrop Laboratories	77

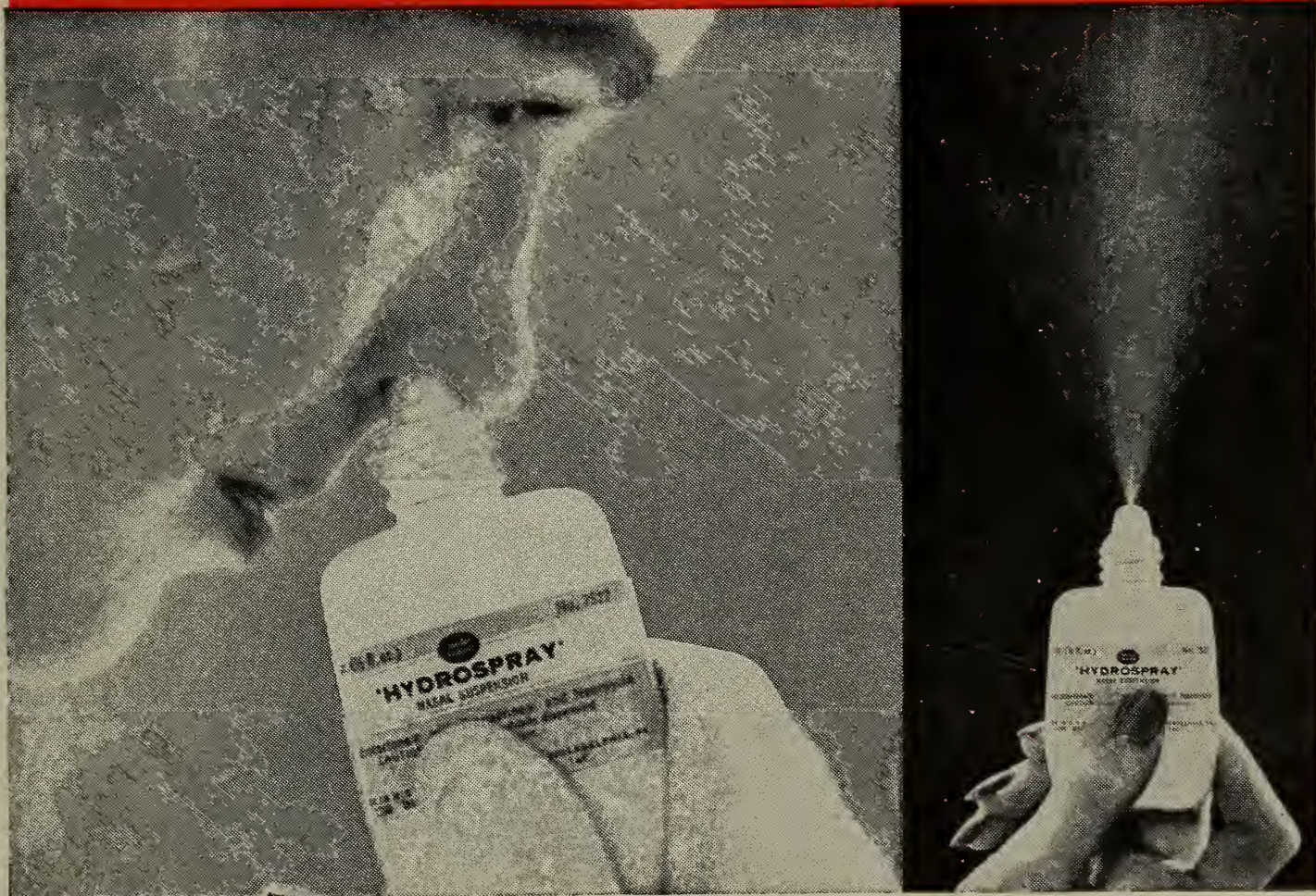
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REFERENCE: 1. Silcox, L. E., *A.M.A. Arch. Otolaryng.* 60:431, Oct. 1954.

The Physician's Bookshelf

By JONATHAN FORMAN, M. D.

Men, Microscopes, and Living Things, by Katherine B. Shippen, (\$3.00. *Viking Press, Inc., New York 17, N. Y.*). From the grandstand of this book, the lives and works of the great biologists pass in review. From this the reader can learn that Man is still at the beginning of understanding that there are many things in the living world that still cannot be explained.

Disorders of Character: Persistent Enuresis, Juvenile Delinquency and Psychopathic Personality, by Joseph J. Michaels, M. D., (\$4.75. *Charles C. Thomas, Publisher, Springfield, Ill.*). The thesis of this work is that there may be psychosomatic disposition specific to the delinquent type of personality having a history of persistent enuresis. The juvenile delinquent and psychopathic personality of this newly formulated impulsive type has a history of persistent enuresis that bespeaks its own psychosomatic substructure and a unique mal-integrated configuration of personality. The pattern of lack of control appears at all levels of the personality, biological, neurological, psychological and sociological.

Reflections on Renal Function, by James R. Robinson, M. D., (\$3.50. *Charles C. Thomas, Publisher, Springfield, Ill.*). This work attempts to bridge the gap between the chapters in general textbooks and the larger treatises on kidney function. The clear statement of fundamental problems will be welcomed by all who read the text.

The Joints of the Extremities: A Radiographic Study, by Raymond W. Lewis, M. D., (\$8.50. *Charles C. Thomas, Publisher, Springfield, Ill.*). Prepared especially for radiologists and orthopedic surgeons to make available methods, observations, and ideas not in common practice which have been developed at the Hospital for Special Surgery in New York City.

Differential Diagnosis: The Interpretation of Clinical Evidence, by A. McGehee Harvey, M. D., and James Bordley III, M. D., (\$11.00. *W. B. Saunders Company, Philadelphia 5, Pa.*). This is not a textbook but rather it attempts to provide a method of approach to diagnosis. It reverses the usual process by beginning with the complex and working towards the simple. In order to be adept the analytical process that must be employed must be used over and over again. One may acquire this concept more readily if one applies a well tested plan such as is presented in this book.

Communicable Diseases, by Franklin H. Top, M. D., (\$18.50. 3rd Edition. *C. V. Mosby Company, St. Louis 3, Mo.*). Infectious diseases al-

though wonderful progress has been made in their control, still remain a threat to mankind and the causative organisms will probably not be eradicated within the foreseeable future. This revised text therefore has a place in every library.

A Comprehensive Review of Dentistry for State Board Examinations, Vincent R. Trapozzano, D. D. S., Editor, (\$8.00. *W. B. Saunders Company, Philadelphia 5, Pa.*). In this second edition some 24 men have contributed to make this the standard review text.

Abdominal Operations, by Rodney Maingot, F. R. C. S., (\$24.50. 3rd Edition. *Appleton-Century Crofts Inc., New York 1, N. Y.*). The first edition of this work appeared in 1948. It has consequently been necessary to revise the whole work drastically to bring it up to date. It has been entirely re-set, eleven new chapters have been introduced, other chapters have been deleted and numerous new illustrations have been incorporated. Aid has been invoked from a number of distinguished contributors to see that specializations in this vast field receive due consideration. This all has been done by the Surgeon to the Royal Free Hospital in London. He has called upon Lester Dragstedt, Denton Cooley, Michael DeBakey, George Peck, and Frances Smith to contribute. Many of our leading American surgeons are acknowledged for their concise accounts of the technique of certain operations which they employ. The book contains 1575 pages of complete technical information on the subject.

Studies on Fertility, edited by R. G. Harrison, (\$4.25. *Charles C. Thomas, Publisher, Springfield, Illinois*). Being volume VI of the proceedings of the Society for the Study of Fertility, London 1954. It represents matured thinking in many fields including zoology, anatomy, physiology, endocrinology, clinical medicine, agricultural sciences, veterinary practice and sociology. It is a book for workers in any of these fields.

Leg Ulcers: Their Causes and Treatment, by S. T. Anning, M. D., (\$4.00. *Little Brown & Company, Boston 6, Mass.*). This is based upon the author's experience in his own clinic during the past 8 years at The General Infirmary at Leeds. It concerns itself primarily with ulcers associated with defective venous return and with ulcers from arterial disease and those associated with arthritis.

Leukaemia Research: The Ciba Foundation Symposium, edited by G. E. W. Wolstenhome and M. P. Cameron, (\$6.75. *Little, Brown & Company,*

Boston 6, Mass.). The informality and intimacy of these meetings permit discussion of current and incomplete research which stimulates lively speculation and argument. They take occasion to refer to much published and unpublished work throughout the world, making in all a most stimulating volume.

Hypertension, edited by G. E. W. Wolstenholme and M. P. Cameron, (\$6.75. *Little, Brown & Company, Boston 6, Mass.*). This is a Ciba Symposium dealing with the humoral and neurogenic factors in hypertension and the effect of it upon the cardiovascular system from the viewpoint of applied physiology.

The Chemical Structure of Proteins, edited by G. E. W. Wolstenholme and M. P. Cameron, (\$6.00. *Little, Brown & Company, Boston 6, Massachusetts*). This is a Ciba Symposium which is primarily concerned with the chemical side of the picture. More specifically with the arrangement of the amino acids in the molecule. Complicated proteins are beginning to yield their structure little by little.

The Dynamics of Personal Adjustment, by George F. J. Lehner, and Ella Kube, (\$7.00. *Prentice-Hall, Inc., New York 11, N. Y.*). This book explains the close relationship that exists between the personal factors and the social forces that operate in human behavior. The book follows a normal person and his problems from infancy to old age and shows how his need changes as he is influenced by parents, teachers, friends and co-workers, mate and children in turn.

Geriatric Anesthesia, by Paul H. Lorhan, M. D., (\$3.25. *Charles C. Thomas, Publisher, Springfield, Ill.*). Along with other interests in the aged, anesthesia now assumes a major position for here it is complicated by so many debilitating diseases. Modern anesthesia affords the aged patient, however, protection which greatly lessens surgical risk. In these lectures not only information about the newer techniques and new drugs is presented, but also the biological changes to be found in most old people which must be considered.

Clinical Biochemistry, by Abraham Cantarow, M. D., and Max Trumper, Ph. D., (\$9.00. Fifth Edition. *W. B. Saunders Company, Philadelphia 5, Pa.*). This is a complete revision of the standard text which has served well for the past 25 years. Since the material included is all relevant to medical practice, it is an excellent bit of reading for those who have been out of school for some time.

Pathology for the Surgeon, by William Boyd, M. D., (\$12.50. 7th Edition. *W. B. Saunders Company, Philadelphia 5, Pa.*). It is just 30 years since the first edition of this valuable text came to the desk at the pathologic laboratory of the hospital. In the intervening years no book has come to take its place. The author

has rewritten the entire book. It is therefore a must on the desk of every surgeon, surgical pathologists and for the resident staff.

The Practice of Dynamic Psychiatry, by Jules H. Masserman, M. D., (\$12.00. *W. B. Saunders Company, Philadelphia 5, Pa.*). For more than a decade the author has been attempting to correlate various physiologic and psychologic concepts of behavior into a comprehensive system which he called Biodynamics. It is a monumental work of nearly 800 pages.

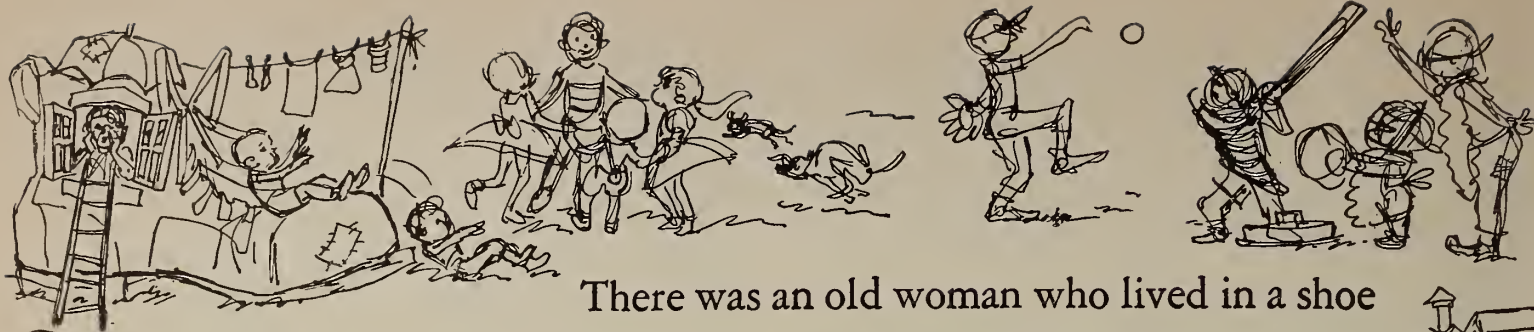
Man in a Cold Environment, by Alan C. Burton, Ph. D., and Otto C. Edholm, M. B., (\$6.75. *Edward Arnold Ltd., London, England*. United States Distributors, *Williams & Wilkins Company, Baltimore 2, Md.*). This is a monograph of the Physiological Society. It is a review of wartime work in the United States, England and Canada. It is therefore a book of reference for anyone interested in environmental problems of Man or directly in the effects of cold upon Man.

Human Relations in Nursing, by Wayland J. Hayes and Rena Gazaway, (\$4.50. *W. B. Saunders Company, Philadelphia 5, Pa.*). This text is designed to arouse the pupil nurse's curiosity about her own society and to provide her with better equipment for observing society so that she may be able to analyze social situations.

Airborn Contagion and Air Hygiene, by William Firth Wells, (\$6.00. *Harvard University Press for Commonwealth Fund, Cambridge, Massachusetts*). For the past 17 years at the Laboratory for the study of Airborne Infection at the University of Pennsylvania and earlier for five years at Harvard University, the author has pursued the studies which make the major contribution to this book and to man's unceasing effort to conquer the unfavorable factors in his environment.

Surgical Forum: Proceedings of the Forum Sessions of the Fortieth Clinical Congress of the American College of Surgeons, (\$10.00. *W. B. Saunders Company, Philadelphia 5, Pa.*). Here in a relatively inexpensive volume one finds the papers that were selected to be read at the Congress. They furnish clues to the direction in which American surgery is going; proof that progress is being and will be made; and facts, opinions and experiences of present-day surgery.

A Textbook of Neurology, by H. Houston Merritt, M. D., (\$12.50. *Lea & Febiger, Philadelphia 6, Pa.*). It is interesting to note how neurology is veering away from its close attachment to psychiatry and coming closer to the fold of internal medicine. This promises to put the subject more and more on a physio-chemical basis and thus more clearly in the realm of scientific endeavor. The appreciation of this trend on the part of the author of this book makes it all of the more value to the internist and general practitioner.

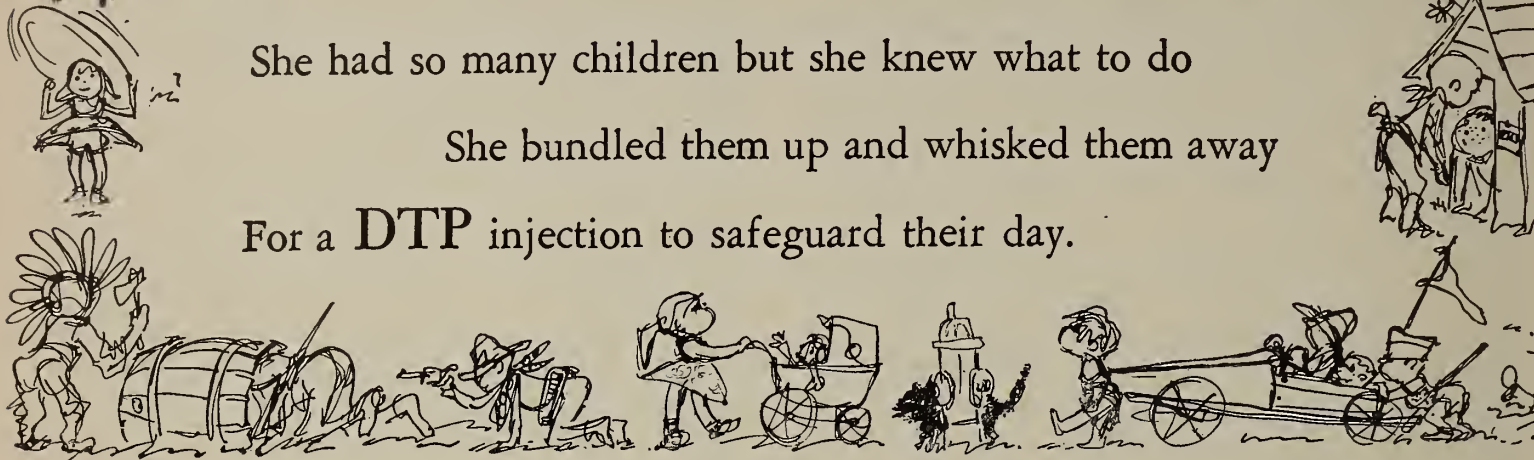


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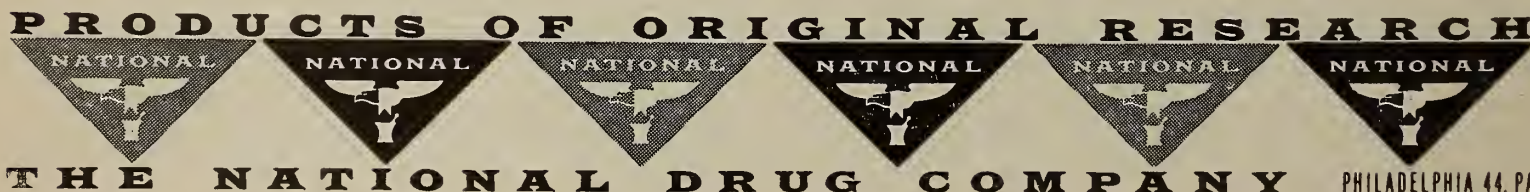
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The Ohio State Medical Journal

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Vol. 52

February, 1956

No. 2

JONATHAN FORMAN, M. D., *Editor*

CHARLES S. NELSON,
Managing Editor—Bus. Mgr.

R. GORDON MOORE,
Asst. Managing Editor

The Use of Drugs in Otolaryngology*

F. W. DAVISON, M. D.

OTOLARYNGOLOGY used to be a surgical specialty. This is no longer true. As evidence I cite the fact that only 20 per cent of 1,000 consecutive new patients seen by me last year needed some type of operative treatment. The other 80 per cent needed good differential diagnosis, advice concerning their living habits, reassurance, minor psychotherapy or drug therapy. If the otolaryngologist is willing and able to assume the role of physician as well as surgeon for those patients having symptoms in his field, his practice will continue to be busy and satisfying.

Time will permit discussion of only a limited number of disease entities, therefore I shall limit my remarks to a discussion of some of the more commonly encountered diseases and to the drugs we find useful in our daily practice.

ACUTE TONSILLITIS, ACUTE ADENOIDITIS AND ACUTE PHARYNGITIS

In my opinion, these acute throat infections respond best to intramuscular injections of penicillin. I usually give two million units of fortified procaine penicillin daily for at least five consecutive days. If one discontinues treatment earlier there is apt to be recurrence. I do not prescribe penicillin by mouth because only one-fifth of the penicillin taken in this manner is absorbed from the gastrointestinal tract. High blood levels of penicillin are necessary because at

The Author

● Dr. Davison, Danville, Pennsylvania, is chief, Department of Otolaryngology and Broncho-esophagology, The George F. Geisinger Memorial Hospital at Danville.

the present time many organisms have become relatively resistant to its action.

All too frequently I see patients who are discouraged because they have relapsing acute throat infections. The history of such cases shows that their previous medical adviser gave one injection of penicillin followed by administration of penicillin by mouth. In our experience these relapses can be prevented if penicillin by injection is continued for at least five consecutive days, that is until sufficient time has elapsed to allow the body to build up an adequate antibody titre.

Undeniably chlortetracycline, oxytetracycline and tetracycline are effective for many of these throat infections if one gives 500 mg. four times daily for five consecutive days. In our experience tetracycline produces unpleasant gastrointestinal symptoms less often than the other two of this group of antibiotics. There will be fewer gastrointestinal symptoms if one uses a dose of 250 mg. four times daily, but the smaller dose also produces slower resolution of fever and other symptoms.

Erythromycin, 400 mg. four times daily for at least five consecutive days is also effective treatment, but unpleasant gastrointestinal symptoms

*From the Department of Otolaryngology and Broncho-esophagology, The Geisinger Memorial Hospital and Foss Clinic, Danville, Pennsylvania.

Presented before the Section on Otorhinolaryngology at the Annual Meeting of the Ohio State Medical Association, Cincinnati, Ohio, April 19-22, 1955.

occur almost as frequently with this drug as with the use of tetracycline.

One of the axioms I find useful is that if one is giving the right amount of the right antibiotic, all symptoms should be markedly improved within a period of 48 hours. If such is not the case then the dose should be doubled, or another antibiotic should be used. The blood concentration of the drug being used does not always parallel the dose taken by mouth.

In my experience antibiotic troches are without value and they frequently produce stomatitis.

Those throat infections complicated by secondary cervical lymphadenitis usually require longer administration of antibiotic therapy, frequently seven to ten days.

As a result of inadequate antibiotic therapy one still sees cases of peritonsillar abscess requiring surgical drainage. In my experience, the simplest and easiest way to drain quinsy is to thrust a sharp, curved, cross-acting forcep through the superior tonsillar crypt into the abscess cavity and then spread the blades. This method produces only a small amount of bleeding and only momentary pain. I mention this method, because I have not seen it described in any of the textbooks.

EAR INFECTIONS

Otitis externa

This is a rather loose term used to describe all degrees of inflammation of the skin of the auditory canal and its subcutaneous tissues. Many articles describing otitis externa indicate that the Gram-negative rods so frequently found in profusion are the etiological agents. In my opinion they are saprophytes and will disappear rapidly if the canal is kept clean and dry. The most important part of the treatment is careful mechanical cleansing, using a small metal suction tip, followed by use of a compressed air jet to blow out debris lodged against the drum. I follow this careful cleansing by insufflation of boric acid powder. I think topical use of antibiotics and sulfonamide preparations should be avoided because they induce contact dermatitis in at least 20 per cent of the patients. If there is much cellulitis or furunculosis, I think it is best to administer one of the antibiotics for a period of five days just as one does in treatment of acute tonsillitis.

Locally applied hydrocortisone is effective in rapidly relieving the inflammation in cases of otitis externa, but its use should be preceded by careful mechanical cleansing at least once daily during the first three or four days of treatment. The ointment can of course be used, but I think the 0.5 per cent hydrocortisone suspension is a little more effective, because it will run down into the depths of the canal.

Acute Otitis Media and Acute Mastoiditis

There is some degree of mastoiditis with every case of acute otitis media, therefore acute otitis

media should be taken seriously, treated promptly, adequately and persistently until the infection is completely eradicated. This in my experience means early myringotomy plus large doses of one of the antibiotics, preferably penicillin given by intramuscular injection. Table I shows how effective this program of treatment has been in practically eliminating acute surgical mastoiditis in our hospital.

TABLE 1. DECREASING INCIDENCE OF "SIMPLE" MASTOID OPERATIONS AT THE GEISINGER HOSPITAL

Year period	No. cases acute otitis media and mastoiditis	No. simple mastoid operations	% requiring mastoidectomy
1937 Pre-sulfa	202	119	58.9
1943 Sulfa	282	74	26.2
1946 Small dose penicillin	247	10	4.0
1949 Large dose penicillin	189	5	2.7
1950 (1-3 million units daily)	158	9	5.7
1951 " "	109	1	0.9
1952 " "	110	3	2.7
1953 Larger dose penicillin	122	0	0
1954 (5-10 million units daily)	65	2	3.0

For a long time I have been convinced of the futility of glycerine ear drops because I have seen so many patients who were not benefited by their use. The advertisements of the ear drops vendors imply that use of glycerine ear drops will extract fluid from the middle ear through an intact drum by osmotic action. In an attempt to settle this question last summer we used three anesthetized cats as experimental animals. We injected normal salt solution colored with methylene blue into the middle ear through the thin bony partition between the mastoid cavity and the middle ear.

A small glass tube was tied into the membranous external auditory canal to act as a manometer. The external auditory canal was filled with glycerine and the height of the glycerine column was measured after a period of one-half hour. At the end of 30 minutes the column of glycerine had risen only two millimeters in each of the three experiments. By knowing the diameter of the glass tube it was possible to calculate that 0.014 cc. of fluid had been withdrawn from the middle ear by osmotic action. This quantity of fluid is so small that it seems obvious that glycerine ear drops are a very ineffectual method of withdrawing fluid from the middle ear.

Table 1 shows that penicillin is much more effective than the sulfonamide drugs in prevention of surgical mastoiditis.

The superiority of penicillin over the sulfon-

amide drugs was also well demonstrated by the careful study reported by Wilcox¹ in 1947. Table 2 appeared in his article. In 42 per cent of his cases the use of sulfadiazine was discontinued and penicillin was used either because the infec-

TABLE 2. COMPARISON OF THE RESULTS OF TREATMENT OF ACUTE OTITIS MEDIA BEFORE THE USE OF SULFONAMIDES (1936-1937), USING SULFADIAZINE (1942-1943), AND USING PENICILLIN (1945-1946)

	Presulfa 1936-1937 202 cases	Sulfa 1942-1943 282 cases	Penicillin 1945-1946 247 cases
Mastoidectomies	119 (58.9%)	74 (26.2%)	10 (4.0%)
Complications	28 (13.9%)	44 (15.6%)	11 (4.4%)
Deaths	3 (1.5%)	2 (0.7%)	1 (0.4%)

tion failed to respond or because signs of sulfonamide intolerance developed. When relying solely on the sulfonamide preparations it was frequently necessary to use transfusions to correct the anemia or neutropenia produced by the sulfonamide drug.

Tetracycline or erythromycin is effective in controlling many early middle ear infections, but at this time I have no statistical data to show that either of these drugs is as effective as penicillin. Because results have been in general so satisfactory with penicillin it is still my drug of choice for treatment of acute otitis media and early mastoiditis. For children under six years I usually give a million units of fortified procaine penicillin intramuscularly every eight hours and for adults I usually give five million units daily. This can be conveniently given as a million units every four hours, omitting the 4:00 a. m. dose.

If the symptoms are marked or the temperature is high I frequently give ten million units daily. Because some of these middle ear infections are due to *H. influenzae*, I usually give in addition 1/2 gm. of distreptocin® intramuscularly every eight hours. Walter Heck² has shown conclusively that there is much less chance of ototoxicity if one gives equal parts of a mixture of streptomycin and dihydrostreptomycin. This is true because dihydrostreptomycin affects primarily the cochlear portion of the inner ear and streptomycin affects primarily the vestibular portion of the inner ear.

Much guesswork can be eliminated if sensitivity cultures are used and in my opinion they should be used for all potentially serious infections.

One still hears talk about the masking effect of antibiotics. So-called masking effects should be no problem for the experienced otologist who knows how to adequately cleanse the external canal, carefully inspect the drum, use a pneumatic otoscope to determine whether or not there is fluid remaining in the middle ear and is not hesitant to do repeated myringotomy when poor mobility shown by the pneumatic otoscope indicates the presence of fluid in the middle ear. To

properly evaluate the progress in a case of otitis media, the drum should be visualized at least every second day.

By following the principles outlined, the men in our department have found it necessary to perform simple mastoidectomy only six times during the last four years. The history in each of these six cases indicates that myringotomy was not performed and that penicillin was given in inadequate dose according to our standards.

Secretory Otitis Media

(Nonsuppurative otitis media, catarrhal otitis media, middle ear effusion)

This condition is becoming much more prevalent with the widespread use of antibiotics. The history in these cases usually runs as follows: One or two months before examination the patient developed a "cold," sore throat and earache. He was given one injection of penicillin followed by a few penicillin or sulfonamide tablets. The pain and fever subsided quickly, but hearing impairment persisted. The drum in such cases is dull, a little retracted, but it may look practically normal. The Rinne test is negative and the Weber test is referred to the affected side if only one ear is involved. The most important single diagnostic sign is *poor mobility* of the drum demonstrated by use of the pneumatic otoscope.

Myringotomy and aspiration, using a small spot suction tube will remove about 1 cc. of thick gummy mucus or serum from the middle ear and the patient's hearing will promptly be restored. I prefer to use a glass spot suction tube because it demonstrates to the patient and the doctor the character and quantity of the exudate removed from the middle ear. This condition is more common in children, especially those having a large adenoid and especially those children having the allergic constitution. Drug therapy has little to offer these patients. I mention it chiefly to condemn the futile use of ear drops.

Chronic Otitis Media and Chronic Mastoiditis

Chronically discharging ears need not continue to be chronic if the doctor uses intelligent differential diagnosis and selects the appropriate treatment. Dr. Torrey recently reviewed the histories of 123 patients with chronically discharging ears seen in our department during the last 18 months. Seventy of these patients had non-marginal perforations. In every case the discharge was cleared up by careful mechanical cleansing, removal of granulation tissue, and insufflation of boric acid powder. We have discontinued making smears and cultures from the discharge because the Gram-negative rods usually present are merely saprophytes. We do not use ear drops and we do not use antibiotics locally. In the few cases in which the discharge was purulent the patient was treated with 5 million units of fortified procaine penicillin

intramuscularly daily, plus 1.5 gm. of distrep-tocin® intramuscularly daily for periods of five to seven days.

Fifty-three of the patients had either a posterior marginal perforation or a perforation through Schrapnell's membrane with obvious cholesteatoma. Thirty-six of these patients had radical mastoidectomy and 17 had modified radical mastoidectomies. All of these patients except one had completely dry ears within three months, and the average healing time was two months. One patient who had a modified radical mastoidectomy will require a complete radical operation. I mention these figures to indicate that more than 40 per cent of the patients who are diagnosed as having chronic otitis media actually have chronic mastoiditis which can be cured only by surgical treatment.

X-ray examination does not tell us when or when not to operate on chronically discharging ears. This decision can and should be made by the otologist after two or three visits at weekly intervals. Following radical mastoidectomy the patient is instructed to use boric acid powder with a hand powder blower twice daily.

ALLERGIC REACTIONS TO PENICILLIN

There are an increasing number of references to fatal penicillin anaphylaxis. No one knows the exact incidence of anaphylactic reactions, but I do know that there have been only three *nonfatal* anaphylactic reactions to penicillin in our hospital during the last 10 years on all services. We have about 10,000 admissions per year and I am sure that 10 per cent of them receive penicillin. Many outpatients also are treated with penicillin by injection, so I think

TABLE 3. DEATHS FROM THE COMPLICATIONS OF OTOLARYNGOLOGIC INFECTIONS FROM 1932 TO 1954 INCLUSIVE

Presulfa period		Sulfa period		Penicillin period	
Year	Deaths	Year	Deaths	Year	Deaths
1932	6	1939	3	1945	1
1933	7	1940	3	1946	0
1934	8	1941	4	1947	3
1935	4	1942	0	1948	1
1936	7	1943	0	1949	0
1937	1	1944	1	1950	3
1938	8			1951-'54	0
Total	41	Total	11	Total	8
in 7 years—		in 6 years—		in 10 years—	
about 6 per year		about 2 per year		less than 1 per year	

it is safe to say that the incidence of fatal anaphylactic reaction is less than 1 per 10,000 patients treated with penicillin by injection. Welch³ estimated in 1954 that there are between 30 and 60 fatal anaphylactic reactions to penicillin in this country. I take time to discuss this subject, because at the present time many doctors have a phobia about the possibility of a fatal anaphylactic reaction. Consequently they use one of the broad spectrum antibiotics or penicillin by mouth or a sulfonamide drug by mouth, all of which in my experience are inferior to the use of penicillin by injection.

Table 3 shows the reduction in mortality from

the complications of otolaryngologic infections by the use of penicillin *by injection*.

Please note that there have been no deaths since 1950.

This experience makes me believe that penicillin by intramuscular injection is still the drug of choice for serious infections due to the Gram-positive cocci.

To keep our perspective, it might be mentioned that last year there were 36,000 deaths from automobile accidents, but no one has advocated giving up the use of the automobile.

The incidence of allergic reactions is the same whether one gives 300,000 units or 3 million units daily. In order to minimize the possibility of allergic reaction to penicillin, I always inquire carefully whether the patient has previously had penicillin and whether or not there has been any adverse reaction to its use. If there is a history of hives or other adverse reaction, indicating allergic sensitivity, I do not use penicillin.

Fortunately we do have drugs available which satisfactorily control the various types of penicillin allergy. If the patient has a sudden anaphylactic reaction, the first drug to be employed is the 1 to 1000 solution of epinephrine 0.3 cc. given subcutaneously every 15 minutes. The next drug of choice for sudden severe reactions is hydrocortisone 100 mg. given by intravenous drip over a period of 2 to 10 hours.

For the milder types of serum sickness allergic reactions, one can use benadryl®, or if the reaction is moderately severe, hydrocortisone 20 mg. by mouth four times daily, gradually decreasing the dose as the reaction subsides.

Another helpful measure to relieve the symptoms of serum sickness type allergic reaction is 1 gm. of procaine in 500 cc. of 5 per cent glucose given by slow intravenous drip over a two hour period twice daily.

For the "id" type of cutaneous reaction, niacin in a flushing dose three or four times daily is effective.

INNER EAR DISEASES

Meniere's Disease (Endolymphatic Hydrops)

My concepts of this disease have been clarified considerably by H. L. Williams' book, titled *Meniere's Disease*.⁴

For the milder attacks, I advise the patient to stop smoking completely and use a salt-poor diet. The salt-poor diet will be better followed if one remembers to prescribe one of the sodium-free salt substitutes. Use of a vasodilator is important, and my preference is for the use of niacin by mouth 1/2 hour before each meal in a dose large enough to produce flushing. Many patients quickly build up a tolerance to niacin, so that the dose of 50 mg. which originally produced a flush may need to be increased to 500 mg. within two or three weeks. If the patient will then discontinue use of niacin for three or four days this tolerance is lost and a lower dose

will again produce flushing. Other measures which I think are important are administration of ammonium chloride using 8 gm. daily for three consecutive days each week and sedation by means of either benadryl® or phenobarbital.

If the patient is seen early, an attack can sometimes be aborted by giving 100 gm. niacin intravenously during a five minute period.

For more severe attacks I hospitalize the patient and give 2.75 mg. histamine diphosphate in 500 cc. of 5 per cent glucose over a two-hour period twice daily. By using the measures just outlined I have not had to advise destructive labyrinthotomy for any patient with Meniere's Disease during the last five years.

Proper management of these cases also demands consideration of psychosomatic factors, because emotional turmoil can be a large etiologic factor. For further consideration of emotional factors I refer you to the excellent article by Fowler and Zeckel⁵ published in the April 12, 1952, issue of *The Journal of the American Medical Association*.

Perceptive Deafness

I think our concepts of the various etiologies of perceptive deafness can be clarified if we realize that the inner ear is subject to all the disorders which also affect the retina of the eye. Vasospastic retinal disease is commonly recognized and diagnosed by ophthalmologists. We as otologists should be willing to recognize that ischemia due to vasospasm is a common cause of perceptive deafness.

Regarding angiospasm in the retina, Duke-Elder⁶ makes the following remarks: "A classically accepted opinion was that all arterial obstruction was due to organic processes—embolism, endarteritis and thrombosis—but the actual observation of spasmodic contractions coming on suddenly, of fleeting duration, appearing and disappearing in different parts of the fundus, associated with similar vascular phenomena elsewhere and coming and going within a few minutes or hours to leave no trace behind have fully established the condition as a clinical entity." . . .

"The entire circulation may cease, segmentation of the blood column with a beaded appearance in the veins being very apparent, until after some time the arteries fill up again in a moment and the veins suddenly resume their normal size." . . . "These spasmodic constrictions may occur with startling rapidity, with great variability as to site, and with such intensity that the vessels may be ophthalmoscopically invisible."

It does not require much imagination to realize that similar angiospastic episodes occur in the inner ear producing deafness, tinnitus or vertigo in various combinations.

The vasospastic factor frequently responsible for inner ear symptoms has been convincingly presented by Hilger and Goltz⁷ and by Juers.⁸

Some of these patients can be helped if treat-

ment is used before ischemic change has caused irreversible damage. One should suspect a vasospastic etiology if the hearing loss is variable and the middle ear is normal. Prompt treatment with vasodilators is essential especially if the hearing impairment is sudden or severe.

The extreme importance of prompt treatment is illustrated by the following two case reports: Both patients were physicians, both had sudden occurrence of deafness, tinnitus and vertigo in one ear. In Case 1, treatment with vasodilators was started within four hours. The follow-up audiogram showed complete restoration of hearing. In Case 2, treatment was delayed for a period of four days. Vertigo ceased in 24 hours, but the follow-up audiogram showed complete loss of hearing for all frequencies above 2048 DV. which resulted in very poor discrimination. This was especially unfortunate because the hearing in his other ear had been practically destroyed by a childhood attack of scarlet fever.

LOCAL ANESTHETIC AGENTS

In more than 25 years of practice I have not seen any toxic reaction to the use of procaine, therefore I continue to use 1 per cent procaine, adding 4 drops of 1 to 1000 epinephrine to each ounce. If one uses a greater total amount of epinephrine the patient is liable to have extreme nervousness and palpitation, a reaction which has erroneously sometimes been attributed to the procaine.

I continue to use 4 per cent cocaine as the agent of choice for surface anesthesia, because I have seen no toxic effects from its use and because it produces rapid and adequate anesthesia. I make it a point to give at least 1.5 grain of one of the quick acting barbiturates such as seconal® at least a half hour before the cocaine is to be used. Another safety measure which I think is important is to add a few drops of aqueous eosin to all cocaine solutions. The red color reminds one not to inject the cocaine solution.

The excellent study of Ireland and associates⁹ showed that cocaine is more rapid in action and produces fewer toxic reactions than does pontocaine.®

NASAL AND SINUS DISEASE

Acute Suppurative Sinusitis

As a generalization, I think it is safe to say that there would be no chronic sinus infection if acute infections were adequately treated. One hears a great deal about the promiscuous use of antibiotics and it is probably true that they are used unnecessarily for many minor infections. This is regrettable for at least two reasons. First, many patients are needlessly sensitized to the antibiotic, and second, many strains of organisms have gradually built up resistance to the commonly used antibiotics. It requires experience and judgement to know when to use and when not to use antibiotics. I do not use

penicillin for minor infections, but I do use penicillin by injection for acute suppurative sinusitis accompanied by either pain or fever.

It remains to be seen whether or not the so-called broad spectrum antibiotics can control serious infections as effectively as penicillin in large dose by intramuscular injection. The nausea, vomiting, diarrhea or pruritis induced by the broad spectrum antibiotics can be serious problems.

In my experience, topical application of antibiotics including aerosol administration has little if any value.

In selecting the antibiotic for a given case, one must balance the probable therapeutic benefit against the probable toxic effects as well as compare the cost and ease of administration. All four of these factors enter into the choice of antibiotic or combination of antibiotics to use in a given case.

It should be emphasized that penicillin is no substitute for drainage. Puncture and lavage of all pus-filled antra is routine treatment. I use an 18 gauge 3½ inch spinal needle connected by rubber tubing to a 20 cc. plunger type glass syringe. I prefer this type of equipment and method because the small needle produces very little trauma and the resistance of the plunger tells me whether the ostium is so completely blocked by edema of the antral lining that additional pressure is not safe. Normal saline is used for irrigation.

I cannot see how the displacement technique can cause penicillin solution to enter pus-filled sinuses or sinuses whose ostia are blocked by the edematous mucosa within. Since penicillin must be administered in such a way that it comes in contact with the infecting microbe, and because the germs are located at various depths within the tissues where they can be reached only by blood-borne penicillin, I use only intramuscular injection.

As Loewe and associates¹⁰ point out, intramuscular administration of 5 million units per day can be expected to maintain a serum concentration of 5 units per ml.

My attention was drawn to the important distinction between bacteriostatic and bactericidal amounts of penicillin by the article of Loewe and associates.¹¹ These authors use the term "minimum lethal dose" to indicate bactericidal concentrations of penicillin and show that it is often four or more times the bacteriostatic concentration. It is important that everyone using penicillin should understand this distinction between bacteriostatic and bactericidal amounts, because the ordinary *in vitro* sensitivity tests by the disc method or by the streak method on blood agar plates indicate only the bacteriostatic concentration.

Quoting Kirby:¹² "In contrast to penicillin the action of the three newer antibiotics is primarily bacteriostatic rather than bactericidal. This

probably accounts for the relatively poor results obtained with aureomycin® and chloramphenicol in the treatment of bacterial endocarditis despite the high degree of *in vitro* susceptibility of the etiologic organisms."

There is something about infections in bone-surrounded cavities which makes them respond poorly and slowly to average doses of penicillin. Probably it is the fact that inflammatory swelling of the soft tissues surrounded by bone constricts the blood supply to these tissues. Table 4 taken from Dr. Fleming's book¹³ published in 1946 indicates that sinusitis may be almost as difficult to cure as complicated septicemias or endocarditis.

TABLE 4. AVERAGE MINIMUM DURATION OF DAYS OF TREATMENT FOR PATIENTS RECEIVING 60,000 UNITS EVERY THREE HOURS

Uncomplicated gonorrhea	1 day
Vincent's angina	2 days
Erysipelas, impetigo	3 days
Carbuncles, cellulitis	5 days
Breast abscesses	7 days
Otitis media and mastoiditis	8 to 10 days
Sinusitis	10 to 12 days
Complicated septicemias	12 to 21 days
Endocarditis	21 to 28 days

In my experience, antibiotic nose drops have little if any value.

Vasoconstrictor nose drops do give some symptomatic relief, but there is always the problem of rebound congestion. Neo-Synephrine® in 0.25 per cent solution or ephedrine 0.25 per cent in normal salt solution are effective and relatively nonirritating.

ALLERGIC RHINITIS

After one has ruled out infectious rhinitis as a cause of nasal symptoms, there still remains the problem of deciding whether the symptoms are due to one or more specific allergens—either food or inhalant—or due to vasomotor rhinitis, the result of emotional turmoil. The latter subject was ably presented by Holmes, Goodell, Wolf and Wolff¹⁴ in their book, entitled *The Nose*.

The otolaryngologist will have difficulty solving many rhinologic problems unless he makes his own allergy studies and unless he takes time to discuss the patient's life situation, considers the patient's living habits and has some awareness of major emotional problems that may be present. We are not doing our duty merely to give symptomatic relief with nose drops and antihistaminic drugs. Dietary habits and possible endocrine factors must also be considered for patients whose chief complaints are nasal stuffiness and postnasal discharge. A high carbohydrate diet is one cause of nasal congestion and subclinical hypothyroidism is another. The latter subject was ably presented by Proetz¹⁵ in the July, 1950, issue of *The Laryngoscope*.

PSYCHOSOMATIC SYMPTOMS

In tabulating 1,000 consecutive new patients, I found that 20 per cent of them had purely functional complaints. The percentage is even higher

if one includes in this group the patients having vasomotor rhinitis and inner ear symptoms. The diagnoses I did list under psychosomatic disease are shown in table 5.

TABLE 5. PSYCHOSOMATIC SYMPTOMS

1. Vascular headache (tension headache)	26
2. No ENT disease	45
3. Anxiety tension state	36
4. Cancer phobia	20
5. Carotid pain	47
6. Crycopharyngeal spasm	25
Total number of patients	199

Drug therapy has a place in the treatment of these patients, but the important factors in their management are: (1) A good history, especially with reference to emotional problems; (2) Careful examination to rule out organic disease; (3) Reassurance; (4) Sedation; (5) Avoidance of local applications or treatments.

Most of these patients do not need a psychiatrist, but they do need a sympathetic listener who is a doctor with the ability to examine adequately the symptomatic areas and who knows how to explain and relieve such symptoms if no organic disease is found.

One of the best articles on this subject was written by Hilger¹⁶ and entitled "Carotid Pain," which appeared in the August, 1949, issue of *The Laryngoscope*. I had this article mimeographed and send a copy to the referring physician each time this diagnosis is used; otherwise he does not know what I am talking about. Hilger points out that pain in the head, face, neck or throat can be due to arteriolar spasm anywhere in the distribution of the carotid artery and that this mechanism is responsible for many of the so-called atypical facial neuralgias. One of my patients with this syndrome had been told that she had an aneurysm.

The drugs I find useful in these cases are nicotinic acid, benadryl,[®] reserpine and pro-banthine.[®] These last two drugs are also helpful in treating patients with cricopharyngeal spasm, better known as globus.

From the data presented it seems evident that the otolaryngologist must be a good physician as well as a good surgeon.

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Coronary Artery Disease
Cases on Increase

There are only a few points that are known with certainty concerning the whole problem of coronary artery disease. We know that there is a strong sex discrepancy in this disease—males predominate over females about three to one. We know that there is a definite familial factor—the disease afflicting more members of certain families and coming in the earlier decades than in other families. Possibly as a corollary of this familial predisposition there is a constitutional or anthropological factor. The well-set, strong, muscular type is more vulnerable than the elongated, lean individual. Excess weight plays a role, although a more minor one.

Tobacco probably also is an aggravating factor, but only to a slight degree. Individuals who have an elevated cholesterol in the blood are also more likely to have coronary sclerosis. What role the diet plays is still being investigated, but we have not as yet a final answer. There is much to make us suspect that a diet high in fat may be detrimental in this regard. The question of exercise is also a point of inquiry.

The number of coronary cases is constantly on the increase. This is a tribute to the medical profession because people are living long enough to develop this condition which has its maximum incidence in the 7th decade. Many people have been cured of cancer, pernicious anaemia, pneumonia and other diseases during the past ten or twenty years, who previously would have died. They now live long enough to develop coronary artery disease. More accurate diagnoses have also greatly increased the number of recognized cases.

The most important questions still remain unanswered, i. e. the prevention of coronary sclerosis or how to actually cure it after it has developed. The great amount of interest and research in this problem throughout the world, makes one hopeful that at least a partial solution to the problem will be forthcoming before long.—Summary of paper, read by Dr. Samuel A. Levine, clinical professor of medicine, Harvard Medical School, at the 64th annual meeting of the Association of Life Insurance Medical Directors of America, Oct. 20, 1955, New York City.

An Appraisal of Piromen® as a Dermatological Chemotherapeutic

ASHTON L. WELSH, M. D., and MITCHELL EDE, M. D.

STUDY of piromen®* in the treatment of various dermatoses was prompted by interest in the stimulating and healing processes demonstrated by this biologically-active, sterile, nonprotein, nonanaphylactogenic pseudomonas polysaccharide, whose therapeutic value appears to be due to a combination of physiological effects.^{1, 2}

Piromen® acts, at least in part, upon the pituitary-adrenal axis. Following intravenous (or intracutaneous) administration to human beings of less than 0.05 gamma per kilogram of body weight, minimal piromen® response is elicited. Ten times this amount has been given to laboratory animals. The most constant response in rats, rabbits, dogs, cats, monkeys (and normal human beings) is a rise in the number of circulating leukocytes.³ The leukocytosis is often preceded by a leukopenia, which occurs within two to three hours after administration, and the leukocytosis usually reaches a peak four to six hours after administration.

In experimental animals, this leukocyte response is superficially similar to that produced by ACTH:^{4, 5, 6, 7} adrenal cortical changes may involve hypertrophy of the zona reticularis, reduction of the zona fasciculata, so that no over-all hypertrophy of the adrenals results; plasma ascorbic acid levels are increased during the leukopenia phase and depressed during the leukocytosis phase.

Effects of subfebrile doses of piromen® are unlike those produced by cortisone.² Notable in the following respects as opposite to the effects of cortisone are: the hyperplasia of thymus, stimulation of lymphoid tissues and exacerbation of the Arthus phenomenon with elevation of antibody titre in rabbits sensitized with egg albumin nitrogen.⁸ Most of the studies on experimental animals point to the conclusion that small doses of piromen® are capable of triggering an endocrine mechanism, but that this mechanism is activated entirely through the hypothalamus and hypophysis has yet to be determined. At this writing, it appears that the reticulo-endothelial and pituitary-adrenal systems participate in response.⁹

Inflammation is resolved, and healing processes in connective tissue are enhanced by the administration of piromen® skin burns which were lethal to untreated rats in 6 to 12 hours were nonlethal in animals receiving daily doses which normally elicit the minimal piromen® response

The Authors

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(a rise in number of circulating leukocytes), but no protective effect was obtained with lower or higher doses; healing of thermal burns in cats given piromen® occurred about 15 days earlier than in untreated animals, with less edema, greater vascularization and natural debridement of necrotic tissue.¹⁰

Scab formations differed in piromen®-treated animals from those in control animals, and healed lesions, in the piromen®-treated group, more closely resembled normal skin. Histological study revealed a richer bed of granulation tissue, and other changes, which led to the conclusion of enhancement of permeability of connective tissue (the mast cells of which, in mice, showed marked structural changes after a single injection of piromen®).¹¹

Favorable response to piromen® therapy has been reported in patients with neurodermatitis,¹² atopic dermatitis, seborrheic dermatitis, acne, pityriasis rubra pilaris and congenital syphilis (when fever-producing dosages were used).¹³ Favorable response to subfebrile dosages has been reported in patients exhibiting varying degrees and types of food allergy (dosages of 2 to 3 gamma, intravenously and intradermally).^{14, 15, 16, 17} Likewise, favorable response to subfebrile dosages has been reported in otitis externa, vesicular eruptions, seborrheic dermatitis and tinea.¹⁸

Intracutaneous, intramuscular and subcutaneous administration of small dosages has been found to be as effective as the intravenously-administered agent.^{9, 19}

METHOD OF ADMINISTRATION

For the purpose of this study, the subcutaneous method of administration was selected (based on experience, with the use of piromen®, acquired prior to initiation of this evaluation). Initial dosage level was set at one gamma, with succeed-

Submitted November 2, 1954.

*Material used in this study was supplied by Travenol Laboratories, a subsidiary of Baxter Laboratories, Inc., Morton Grove, Illinois.

ing dosages of one gamma for two injections, then increased by one gamma every fourth injection, until the one cubic centimeter level was reached, and there held. Administration was (usually) once weekly, with daily, twice weekly and thrice weekly injections only in acute situations. Maintenance schedules of one injection monthly were adopted as soon as feasible, and response was the determining factor in size of dosage and time interval.

Sites of injection (upper deltoid areas) were rotated until it was determined that the only side-effects from subcutaneous administration were (rarely) slight erythema and sensation of warmth in the area of injection. There were no instances of activation at the site of any previous intradermal injection, and no other untoward cutaneous manifestations.

REACTIONS

There were no evidences of systemic reactions (malaise, elevation of temperature, irritability, fatigue). Many patients reported an after-feeling of well-being (such reports being too frequent for explanation by psychological factors). No patient reported such feeling following any placebo administrations.

PROCEDURE OF STUDY

All patients in this series received concomitant therapy, consisting of irradiation measures (where indicated), topical and internal agents (as indicated), identical therapy having been used by these investigators previously so that they were thoroughly familiar with response which

might be expected. Controls, therefore, are considered as responses on treatment regimens without piromen,[®] in comparison with identical treatment regimens plus piromen.[®] The bacterial polysaccharide was never used alone, inasmuch as the nature of the agent proclaimed it to be an adjunctive measure, and the reported experience of other investigators had confirmed the usefulness of piromen,[®] as such.⁹

Study was pursued for a period of 12 months. Patients on therapeutic regimens plus piromen[®] received, during 3 months, an average of 40 gamma; during 6 months, an average of 135 gamma; during 9 months, an average of 260 gamma; and during 12 months, an average of 400 gamma. Patients on regimens for less than 3 months received amounts varying from 1 to 29 gamma, depending on time interval before disappearance from observation. (Patients in the group "Contact Dermatitis—Rhus," received one gamma every third day, except in acute situations where dosages were larger.)

Adjunctive therapy with piromen[®] was given to 1,037 patients. Comparison of effectiveness of therapeutic regimens plus piromen,[®] as contrasted with control regimens without piromen[®] is reported in the accompanying tables.

CHRONIC INFECTIOUS ECZEMATOID DERMATITIS

Four hundred and twelve patients with infectious eczematoid dermatitis received therapy with piromen[®] adjunctively. Of this group, 356 patients (86.4 per cent) showed greater improvement on therapeutic regimens including pir-

TABLE 1—ECZEMATOUS ERUPTIONS—AND URTICARIA

	No. of Cases Females (F) Males (M)	Age-Range in years	Patients on Ther- apeutic Regimens WITHOUT Piromen					Patients on Identical Therapeutic Regimens PLUS Piromen					Greater Improvement PLUS Piromen	Equal Improvement PLUS Piromen
			Less than 3 mos.	3 mos.	6 mos.	9 mos.	12 mos.	Less than 3 mos.	3 mos.	6 mos.	9 mos.	12 mos.		
750 Patients 484 (F) 266 (M)														
Infectious Eczematoid Dermatitis	255 (F) 157 (M)	12-80 7-75	16 22	13 5	7 3	4 3	51 29	56 46	48 16	42 26	30 13	79 56	218 138	37 19
Stasis Dermatitis	8 (F) 5 (M)	37-76 54-74	3 1	— 1	— —	1 1	— 1	1 2	1 1	— 1	3 —	3 1	1 1	7 4
Seborrheic Dermatitis	32 (F) 14 (M)	16-77 26-63	3 4	1 —	1 —	1 —	11 2	11 7	6 —	6 —	5 2	4 5	20 3	12 11
Contact Dermatitis Rhus	18 (F) 15 (M)	13-64 5-70	1 —	— —	1 —	— —	2 —	16 15	2 —	— —	— —	— —	5 5	13 10
"Other"	95 (F) 35 (M)	20-76 26-73	37 13	8 —	— 1	1 —	11 7	50 14	10 2	8 4	6 5	21 10	61 18	34 17
Atopic Dermatitis	57 (F) 28 (M)	3-67 3-44	9 2	1 1	1 —	— 1	18 8	13 8	5 6	5 1	3 1	31 12	44 24	13 4
Urticaria and Angioneurotic Edema	12 (F) 11 (M)	12-59 7-65	5 3	1 2	— 1	— —	3 1	5 1	1 1	4 2	— —	2 7	6 7	6 4
Prurigo Nodularis	1 (F)	36	—	—	—	—	—	—	—	—	1	—	—	1
Dermatitis Medicamentosa	6 (F) 1 (M)	26-60 37	— —	2 1	— —	— —	3 —	1 —	1 —	1 —	— —	3 1	3 —	3 1
Totals	750		119	36	15	12	147	246	100	100	69	235	554	196

TABLE 2—ERUPTIONS OF HEMATOGENOUS ORIGIN

			Patients on Ther- apeutic Regimens WITHOUT Piromen					Patients on Identical Therapeutic Regimens PLUS Piromen					Greater Improvement PLUS Piromen	Equal Improvement PLUS Piromen
			Less than 3 mos.	3 mos.	6 mos.	9 mos.	12 mos.	Less than 3 mos.	3 mos.	6 mos.	9 mos.	12 mos.		
38 Patients		No. of Cases												
24 (F)	Females (F)													
14 (M)	Males (M)													
		Age-Ranges in years												
Erythema Multiforme	5 (F) 5 (M)	7-64 29-56	— 1	— —	— —	— —	1 —	1 —	1 —	— 1	— 1	3 3	4 3	1 2
Dermatitis Herpetiformis	7 (F) 3 (M)	36-58 29-64	3 —	— —	— —	— —	2 —	1 2	1 —	3 —	1 —	1 1	1 —	6 3
Granuloma Annulare	1 (F) 1 (M)	30 5	— 1	— —	1 —	— —	— —	— —	— —	— —	— —	1 1	— —	1 1
Lupus Erythematosus	11 (F) 5 (M)	32-57 27-64	4 2	2 1	1 —	— —	3 1	2 3	— 1	2 —	1 —	6 1	— —	11 5
Totals	38		11	3	2	—	7	9	3	6	3	17	8	30

omen,[®] than on identical regimens without piromen.[®] Fifty-six did not show any increase in favorable response when piromen[®] was included in the treatment program.

One hundred fifty-three patients in this group received treatment for previous episodes of the disease. Such patients had been cleared on regimens consisting of topical, internal and actinic therapy, varied according to individual requirements. Within intervals ranging from a few weeks, to a few months, or a few years, the same patients returned with recurrences of their individual problems. Some patients were cleared a second time; some, a third time. Comparison of rate of clearance and frequency of recurrence following addition of piromen[®] to treatment programs warrants the conclusion that patients on plus-piromen[®] regimens cleared sooner than they had on identical regimens without piromen[®]; that recurrences were more infrequent, and more widely spaced.

ATOPIC DERMATITIS

Of the 85 patients with atopic dermatitis, 68 (80.0 per cent) showed greater improvement on the plus-piromen[®] regimens. Seventeen patients failed to show increased response on plus-piromen[®] programs. Forty-one of this group had received therapy for previous episodes. These patients cleared more rapidly on plus-piromen[®] regimens, and experienced more prolonged remissions of their problems than they did on identical treatment programs without piromen.[®]

URTICARIA AND ANGIONEUROTIC EDEMA

Of the 23 patients with urticaria and angioneurotic edema, 13 (56.5 per cent) showed greater improvement on the plus-piromen[®] regimens than did patients on identical regimens without piromen.[®] Ten patients failed to show change in rate or type of response on the plus-piromen[®] programs. Sixteen of this group had received previous conventional therapy. All but

TABLE 3—INFLAMMATIONS

			Patients on Ther- apeutic Regimens WITHOUT Piromen					Patients on Identical Therapeutic Regimens PLUS Piromen					Greater Improvement PLUS Piromen	Equal Improvement PLUS Piromen
			Less than 3 mos.	3 mos.	6 mos.	9 mos.	12 mos.	Less than 3 mos.	3 mos.	6 mos.	9 mos.	12 mos.		
147 Patients		No. of Cases												
97 (F)	Females (F)													
50 (M)	Males (M)													
		Age-Ranges in years												
Psoriasis	83 (F) 47 (M)	7-72 13-70	23 8	1 2	— 2	1 1	13 9	24 13	14 7	11 9	5 1	29 17	6 2	77 45
Lichen Planus	5 (F)	30-61	3	—	1	—	—	1	4	—	—	—	—	5
Aphthous Stomatitis	3 (F) 1 (M)	25-58 47	— —	— —	1 —	— —	1 —	1 —	— —	— —	— —	2 1	— —	3 1
Pityriasis Rosea	2 (F) 1 (M)	21, 45 30	1 —	— —	— —	— —	1 —	1 1	1 —	— —	— —	— —	— —	2 1
Purpura	1 (F)	58	1	—	—	—	—	—	—	—	—	1	—	1
Erythema Perstans	2 (F)	55, 57	—	—	—	—	—	1	—	—	1	—	—	2
Dermatitis Repens	1 (F) 1 (M)	46 74	1 —	— —	— —	— —	— —	— 1	— —	— —	— —	1 —	— —	1 1
Totals	147		37	3	4	2	24	43	26	20	7	51	8	139

3 of these patients showed marked increase in rate of response when piromen® was added to their treatment schedules.

Patients with atopic dermatitis, urticaria and angioneurotic edema, who had complained of headache, nervousness, restlessness and fatigue as manifestations of allergic states reported, particularly, "the lift" beforementioned. They "felt better" . . . they "wanted to get up in the morning" . . . confirming the conclusions of Fitch and Washburne.²⁰ Edema (such as swelling of the eyelids) tended to disappear promptly upon institution of piromen® therapy (which may suggest some correlation with enhancement of tissue permeability).

CONTACT DERMATITIS

One hundred sixty-three patients with contact dermatitis received piromen® as a therapeutic adjuvant. Included in this group were 33 patients with dermatitis venenata due to Rhus toxicodendron. The remaining 130 patients had dermatitis due to contact reactions to various other sensitizing agents. The latter group, for the most part, was made up of patients with chronic or recurrent eruptions. In the composite group, 89 patients (54.6 per cent) showed greater

progress on plus-piromen® regimens. Seventy-four patients evidenced no definite improvement when piromen® was added to conventional therapy.

DERMATITIS VENENATA

Of the patients with dermatitis venenata, only 10 (30.3 per cent) seemed to progress more favorably on the plus-piromen® regimen. These 10 patients had prolonged episodes due either to superimposed chemical reactions from therapy or to infectious eczematoid complications. In contrast, 79 patients (60.7 per cent) with chronic or recurrent contact dermatitis due to other causes showed greater response on plus-piromen® therapeutic programs.

Four of the patients with Rhus dermatitis, and 78 of the patients with contact dermatitis due to other causes had had previous conventional treatment, identical to that pursued during the plus-piromen® regimen period. The rapidity of response and the permanence of disease-remission were enhanced by the addition of piromen® to treatment programs.

MISCELLANEOUS DISEASES

In the remaining 354 patients, who had diseases other than those mentioned above, and as in-

TABLE 4—INFECTIONS

64 Patients 42 (F) 22 (M)	No. of Cases Females (F) Males (M)	Age-Range in years	Patients on Ther- apeutic Regimens WITHOUT Piromen					Patients on Identical Therapeutic Regimens PLUS Piromen					Greater Improvement PLUS Piromen	Equal Improvement PLUS Piromen
			Less than 3 mos.	3 mos.	6 mos.	9 mos.	12 mos.	Less than 3 mos.	3 mos.	6 mos.	9 mos.	12 mos.		
Acne	20 (F) 3 (M)	13-57 26-55	2 1	— —	1 —	1 —	7 —	6 1	4 1	1 1	— —	9 —	— —	20 3
Cellulitis	1 (F) 1 (M)	61 39	— 1	— —	— —	— —	— —	1 1	— —	— —	— —	— —	— —	1 1
Epidermophytosis	5 (F) 2 (M)	24-60 47, 55	2 1	— —	— —	— —	1 1	2 1	— —	1 —	— —	2 1	— —	5 2
Folliculitis	3 (M)	31-59	1	—	—	—	1	—	—	1	1	1	1	2
Furunculosis	1 (F) 1 (M)	57 38	— —	— —	— —	— —	1 —	— 1	— —	— —	— —	1 —	— —	1 1
Herpes Simplex	5 (F) 3 (M)	16-51 13-50	3 —	1 —	— —	— —	— —	4 2	1 1	— —	— —	— —	— —	5 3
Herpes Zoster	4 (F) 2 (M)	18-41 44, 54	— —	— —	1 —	— —	— —	— 2	— —	1 —	1 —	2 —	— —	4 2
Impetigo	2 (M)	33, 36	2	—	—	—	—	1	1	—	—	—	—	2
Intertrigo	1 (F) 1 (M)	25 62	1 1	— —	— —	— —	— —	— —	— —	1 —	— 1	— —	— —	1 1
Moniliasis	1 (M)	54	1	—	—	—	—	1	—	—	—	—	—	1
Paronychia	2 (F)	36, 38	1	—	—	—	1	1	—	—	—	1	—	2
Pustular Bacteride of Andrews	1 (F)	41	—	—	—	—	—	—	1	—	—	—	1	—
Pyoderma	1 (F)	50	—	—	—	—	—	1	—	—	—	—	—	1
Pyogenic Granuloma	1 (F) 1 (M)	62 25	1 1	— —	— —	— —	— —	— 1	— —	1 —	— —	— —	— —	1 1
Sycosis Barbae	1 (M)	43	1	—	—	—	—	—	1	—	—	—	—	1
Tinea Corporis	1 (M)	29	—	—	—	—	1	—	—	—	1	—	—	1
Totals	64		20	1	2	1	13	26	10	7	4	17	2	62

TABLE 5—MISCELLANEOUS

	No. of Cases Females (F) Males (M)	Age-Range in years	Patients on Ther- apeutic Regimens WITHOUT Piromen					Patients on Identical Therapeutic Regimens PLUS Piromen					Greater Improvement PLUS Piromen	Equal Improvement PLUS Piromen
			Less than 3 mos.	3 mos.	6 mos.	9 mos.	12 mos.	Less than 3 mos.	3 mos.	6 mos.	9 mos.	12 mos.		
38 Patients 28 (F) 10 (M)														
Acarophobia	1 (F)	64	—	—	—	—	—	1	—	—	—	—	—	1
Acro Dermatitis Chronicus Atrophicans	1 (F)	57	—	—	—	—	1	—	—	—	—	1	—	1
Alopecia Areata	5 (F) 1 (M)	28-67 23	3	—	—	—	1	1	1	1	—	2	—	5
Ariboflavinosis	1 (F)	70	—	—	—	—	1	—	—	—	—	1	—	1
Epidermolysis Bullosa	1 (F)	29	—	—	—	—	—	1	—	—	—	—	—	1
Factitia	1 (F)	32	—	—	1	—	—	—	—	1	—	—	—	1
Glossodynia	1 (M)	39	—	—	—	—	1	—	—	—	—	1	—	1
Ichthyosis	1 (F) 1 (M)	41 17	—	—	1	—	—	1	—	—	—	—	—	1
Keratoderma Climactericum	2 (F)	50, 56	2	—	—	—	—	—	1	—	—	1	—	2
Lichen Simplex Chronicus	3 (F) 5 (M)	41-57 34-62	2 1	—	—	—	—	1 2	—	—	—	2 1	1	2 5
Migraine Headache	1 (F)	37	—	—	—	1	—	—	—	—	1	—	—	1
Periarthritis Nodosa	1 (F)	49	—	—	—	—	—	—	—	—	—	1	1	—
Pruritus Ani	4 (F) 2 (M)	23-64 40, 68	1	—	1	—	2	1	—	1	1	1	2	2
Pruritus Vulvae	3 (F)	23-63	—	—	1	—	2	—	—	1	1	1	—	3
Schamberg's Disease	1 (F)	33	—	—	—	—	—	—	—	1	—	—	—	1
Transitory Benign Plaques	1 (F)	39	—	—	—	—	1	1	—	—	—	—	—	1
Undulant Fever	1 (F)	45	—	—	—	—	1	—	—	—	—	1	—	1
Totals	38		9	—	4	1	13	11	3	6	5	13	4	34

licated in the tables, the response was about equal to regimens-plus-piromen® and identical therapeutic regimens without piromen.® In several patients in this group where the basic disease was complicated by eczematization, due either to chemicals used therapeutically or contacted accidentally, or to superimposed exogenous or endogenous infections, some increased response in those secondary phenomena was noted on plus-piromen® regimens.

SEBORRHEIC DERMATITIS

The response in patients with seborrheic dermatitis exemplifies the observations recorded in the preceding paragraph. Twenty-three patients (50.0 per cent) of a group of 46 with seborrheic dermatitis showed greater response on plus-piromen® programs. (The majority of these patients had superimposed infectious eczematoid dermatitis or chemical dermatitis due to therapeutic agents.) Sixteen patients did not demonstrate any increased response. Seven patients received therapy for intervals too short for accurate appraisal. Twenty-three patients had had previous identical treatment. Only four patients with uncomplicated seborrheic dermatitis

showed increased favorable response on plus-piromen® regimens.

OBSERVATIONS

Recurrence of symptoms in patients who discontinued therapy too soon, and who returned for additional therapy, was observed to be gradual. In no case did symptoms appear to be more severe after withdrawal of the drug.

In no case did piromen® mask the symptoms and surface signs of infection. Piromen® seemed to exert some synergistic effect, the mechanism of which cannot be explained, and plus-piromen® therapeutic regimens were generally more effective than identical regimens without piromen.®

Piromen® appeared to strengthen defense mechanisms against foci of infection.

No untoward effects were observed from the addition of piromen® in subpyrexial dosages to therapeutic regimens of patients in the 55 to 80 years-of-age groups. Based upon observations recorded in this study, piromen® is not contraindicated for older dermatological patients.

CONCLUSIONS

Piromen® is an effective adjuvant to appropriate conventional therapy in dermatoses involving an allergic factor, particularly infectious eczem-

atoid dermatitis, atopic dermatitis, urticaria, angioneurotic edema and contact dermatitis.

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Problems of Antibiotic Therapy

The problem of antibiotics in the therapy of the common cold and related infections is acute and much debated today. . .

Certain groups of patients merit special consideration for antibiotic therapy in the presence of acute upper respiratory infections: those with diabetes, chronic pulmonary disease, bronchial asthma of the infectious type, the nephritic, those with rheumatoid or rheumatic diatheses, the very young and the very aged, and those who are prone to recurrent middle ear and sinus infection.

Other groups might well be added to this. In these patients, we country doctors may merit less academic flagellation for the "injurious" use of antibiotics.—James F. Gleason, M. D.: *J. M. Soc. New Jersey*, 52:619, 1955.

KEEPING UP WITH MEDICINE

- ILLEGITIMATE live births increased from 88,000 in the year 1938 to 142,000 in 1950. According to recent statistics 44 per cent of illegitimate births were to girls 15 to 20 years of age.

* * *

- OBESITY, a form of malnutrition due to over-eating, unbalanced diet, or other causes, is one of the outstanding health problems of the United States.

* * *

- WE MUST NOT allow ourselves the foolish idea that hereditary and environmental etiologic agents cannot co-exist—that if a condition is hereditary, it cannot be reproduced, or even modified, by an infectious or dietary agent; and conversely, that if a condition is clearly due to an infectious agent or to a dietary deficiency it cannot at the same time be conditioned by the genes.

* * *

- THE CAUSATIVE factor in atherosclerosis is a medial necrosis associated with hemorrhages. This may be associated with protracted hypertension like that seen after intravenous administration of adrenalin in the dog. These hemorrhages dissect the coats of the vessels. This does not exclude other mechanisms. These necroses may be due to toxic agents such as infections or of chemical of exogenous-endogenous metabolic origin.

* * *

- THE PRINCIPAL structural changes encountered in the common forms of senile arteriosclerosis can be reproduced in the experimental state. The most satisfactory reproduction requires the induction of hypercholesterolemia in animals with defects in the vascular wall that leads to active medial degeneration and intimal proliferation.

* * *

- THE MAJOR changes in the incidence of atherosclerosis and mortality from atherosclerotic heart disease seen in several populations during World War II are consistent with the theory that the diet is a major factor in the development of atherosclerosis in man.

* * *

- THERE IS no evidence that the great differences that exist between different populations in the age-incidence and the severity of atherosclerosis depends in any way on climate, race, intercurrent diseases, or the adequacy of public health or medical services. Dietary manipulation of both total calories and total fat are the most effective known ways for the correction of abnormal elevation of serum lipids. Severe restrictions, however, of less than 50 grams a day is unsound because it is difficult to maintain a sound nutrition under such restriction. But the warning is hardly necessary, for such a diet is totally unacceptable to the average American and so will not be followed anyway.—J. F.

How Well Do We Treat Bacterial Infections?

ROBERT C. KIRK, M. D.

THE author has recently been asked to discuss three fatal cases occurring in three separate hospitals. In each case the reason for medical management followed closely upon simple diagnostic or surgical procedures. Endoscopy in one, tonsillectomy in another, in the third, a fatal septic course following a prostatic massage. As readers of current literature have already surmised, the common denominator in these three cases was infection with a resistant *Staphylococcus aureus* bacillus. This is not to be a report of the tremendous medical effort unsuccessfully expended nor to emphasize the irreplaceable family loss, but rather a look back and a look ahead at bacterial infections.

DISINFECTION

It was Semmelweis—the undoubted father of the whole subject—who introduced disinfection of the surgeon's hands with chlorinated lime as a preventive of puerperal fever in 1848. In spite of its striking success he was derided and opposed and died a disappointed man.

One hundred years later the subject has by no means reached its finality. At the present time it would appear that the quarternary ammonium compounds have replaced chlorinated lime, however, it is said that the antiseptic film formed on the surgeon's skin actually can be broken by serum and the hand again gives off numerous bacteria.³

ANTISEPSIS

In 1868 Lister introduced the antiseptic treatment of wounds. It may be interesting to recall one of his first cases: "The tibia, which was broken about its middle, lay exposed in a wound occupying almost the entire length and breadth of the inner aspect of the leg, the skin having been stripped back so as to lay bare the gastrocnemius as well as the bone . . . chloroform having been administered, the acid (carbolic) of full strength was applied with great freedom, the contused mass being repeatedly squeezed to introduce the liquid to insinuate itself into all the interstices, including that between the riding fragments of the tibia." It is a tribute to the species that the patient recovered.³

As late as 1937 the following passage from a well known textbook of surgery, "The wound cavity may be temporarily packed with gauze soaked in some suitable antiseptic (for example, iodine, carbolic lotion 1 in 20, a strong solution of brilliant green, or any other that the surgeon favours," gives some idea of the thinking in wound antisepsis. Of course penicillin is the

The Author

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standard application to wounds today but with the problem of the staphylococcus getting out of hand it is time to resume the search for further wound antiseptics. A promising one under study in England this year is hibitane, but until its efficiency is established the use of 1 per cent proflavine sulfathiazole powder should be strongly thought of particularly if penicillin resistance is established.

CHEMOTHERAPY⁴

The explanation of the phenomena of infectious diseases in terms of microorganisms, protective antibodies and phagocytes is a magnificent contribution inspired by such great men as Koch, Pasteur and Metchnikoff. However, there are many, many unanswered questions which it may be interesting to touch upon: Why if I lie out all night in the snow am I liable to get pneumonia? Why can chickens be infected with anthrax only if chilled? Why can the virus of herpes simplex be present during most of the life of the host and only occasionally make itself known? How could any known explanation of transmissibility account for the influenza epidemic of 1918 where to the best of anyone's knowledge the first case appeared in Boston and was traced to cases in a destroyer flotilla when other foci appeared in many parts of the United States within a few days?

Finally, there are the extraordinary differences in the effects produced by the same pathogen in different species, a difference which must surely be due to nonspecific host factors. Thus, as Murray (1953) has pointed out, the disease produced by *Listeria monocytogenes* "is predominantly a meningo-encephalitis in cattle, sheep, goats and swine; but a metritis, with abortion, occurs in sheep, goats, swine and cattle and the microorganism has been found in the genital tract of rabbits, guinea-pigs, horses, cattle and humans; in birds there is a marked myocarditis which is also frequent in guinea pigs; the disease is distemper-like in the fox; there is conjunctivokeratitis, which is quite peculiar in rabbits, guinea-pigs and horses; in many of these and in other animals it is a systemic infection marked

Submitted June 8, 1955.

by a necrotic hepatitis, but in the ferret it is a mild disease, almost a carrier state. In man many cases have been meningitis, some septicemic; and a few cases in which *Listeria* has been isolated were clinically infectious mononucleosis."

Staphylococcus aureus causes three kind of mastitis in cows—chronic catarrhal, chronic fibrous, acute gangrenous—and nobody knows why.

In spite of the fringe of doubts such questions raise let us explore the positive accomplishments.

The first chemotherapeutic agent against bacteria was arsphenamine but it wasn't until 1935 that the sulfonamide derivatives turned the tide and today it would seem our biggest problem is making a choice of drugs. It is now important to recall some of the "do's and don't's" of such choices. About penicillin it is probably enough to remember that it is bactericidal and primarily effective against actually multiplying organisms.⁵ It is the only nontoxic drug known today. No one, as far as I know, has ever determined its lethal dose. That is not to say it is harmless, as we all know, but the reactions from penicillin are not those of toxicity but of sensitivity, which is an entirely different thing and needs no further comment here.

Bacitracin is also bactericidal but in large doses it is probably nephrotoxic. Streptomycin is the third well known bactericidal agent but its penalty of 8th nerve deafness, or the damage to the vestibular apparatus by dihydrostreptomycin makes their selection for treatment a grave responsibility.

The tetracycline products are all bacteriostatic and of course have their greatest usefulness in the treatment of gram-negative organisms although they are referred to as broad spectrum. Their complications are liver damage in excessive doses and intestinal disturbances which may be considerably disabling, although I have seen none with chlortetracycline in moderate doses. Chloramphenicol and erythromycin are also bacteriostatic but chloramphenicol may cause aplastic anemia and erythromycin caused diarrhea in two cases in which I have used it.

So far we have for the most part an optimistic view but there are shadows on the horizon. By far the most ominous is the development of organism resistance. The following statistical findings by Finland⁶ are self-explanatory:

Seventy-three per cent of the strains of pathogenic staphylococci isolated from all sources in Boston City Hospital were resistant to penicillin.

Twenty-four per cent to chlortetracycline (in hospital infections).

Thirty-two per cent to oxytetracycline.

Fifty-five per cent were staphylococcal-penicillin resistant in patients who had never previously received penicillin. This occurs by transfer of

resistant strains within the hospital or by transfer within the community.

The solution offers a real challenge to investigators in this field.⁵ At the present the prospect is bleak. There are, however, some things that we physicians could do as pointed out by Paul Clough in a recent editorial²: "The most fundamental but most difficult measure would be curbing the indiscriminate dispensing of antibiotics in the community for undiagnosed infections, ordinary 'colds' and other minor illnesses. This has now been shown to be not only useless and wasteful but in varying degree dangerous and a positive disservice to the patient, and to the community at large."

CONCLUSION

It is hoped, to paraphrase from Sir Henry Cohen,¹ that some of these thoughts and problems will inculcate in us a humility which is the sweet shield against intellectual arrogance.

ADDENDUM

Since this article was written the following papers confirming the importance of the subject should be required reading for all physicians dealing with infections:

Finland, Maxwell: Guest Editorial—Antibiotic-Resistant Micrococcal Infections. *J. A. M. A.*, 158:188-190, May 21, 1955.

Editorial: Antibiotics, Staphylococci and Enterocolitis. *New England J. Med.*, 253:201-203, August 4, 1955.

Weinstein, Louis: Failure of Chemotherapy to Prevent the Bacterial Complications of Measles. *New England J. Med.*, 253:679-683, A 55, October 20.

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The Use of Anticoagulants In Atherothrombosis

It is becoming clear that anticoagulant therapy alters the natural course of events in many cases of cerebral thrombosis and postpones indefinitely the arrival of a threatening stroke. However, it is not possible at present to estimate its real value since many strokes which were apparently prevented by giving anticoagulants at the stage of warnings might not have occurred had nothing been done. In some cases transient ischemic attacks have recurred for two or three years and then subsided without resulting in a stroke. There is need of a careful study which will compare the progress of a group of cases receiving anticoagulants with a similar control group in which anticoagulants are not used.—C. Miller Fisher, Boston: *Minnesota Medicine*, 38:839, December, 1955

Indications for Urologic Investigation in Infancy And Childhood

(A Pediatric Review)

LOUIS SCHWAB, M. D.

SOME degree of congenital malformation of the genitourinary tract occurs in 10 to 14 per cent of the newborn population, and 30 to 40 per cent of all hospital admissions on pediatric surgical services involve urologic operations.^{1,2} These figures alone indicate the dimensions of the problem presented by genitourinary anomalies.

Of these anomalies the most insidious are those involving partial but not obvious obstruction to urine flow. The disastrous consequences of the undiagnosed and untreated obstruction are well known: progressive dilatation of the tract proximal to the obstruction, often recurrent infections, eventual bilateral hydronephrosis, destruction of renal parenchyma incident to hydronephrosis, with renal crippling or early uremic death. The fact that this sequence of events may often result from defects readily correctable by surgical means makes diagnostic errors or oversights in this area particularly tragic.

It is the purpose of this brief review, therefore, to emphasize once again the often misleading nature of the symptomatology of urinary disease in the pediatric age group and to re-state the indications for thorough urologic investigation in these patients. The classic papers of Merdith Campbell have been heavily relied upon.^{3,4}

The principal clinical situations requiring urologic investigation will be listed in the order of the likelihood that they might lead to diagnostic errors.

(1) GROWTH RETARDATION

While by no means the most common symptom of urinary disease, growth retardation is perhaps the one sign least likely to draw attention to the urinary tract as the possible source of difficulty. When due to urologic disease growth retardation usually is associated with major renal insufficiency. It is, therefore, a relatively late herald of urinary disease. It is for this very reason, however, that its significance should be appreciated at the earliest possible moment. The following case history illustrates this point:

CASE REPORT

Case 1. This white male child was first hospitalized at the age of 4½ years for the treatment of atypical pneumonia. Height and weight were below the twenty-fifth percentile. The specific gravity of the urine was 1.010.

Submitted November 22, 1955.

The Author

● Dr. Schwab, Cincinnati, is an attending pediatrician at The Cincinnati General Hospital and member of the Cardiology Department of The Cincinnati Children's Hospital.

At 7 years of age he was again hospitalized for a febrile illness of unknown etiology. Urine specific gravity was 1.009, a trace of albumin was present, and height and weight were now below the third percentile. Anemia and an elevated serum phosphorus were also noted. The possibility of chronic genitourinary disease was considered, but the diagnosis was not pursued.

One year later he was re-admitted because of continued growth retardation, anemia, polydipsia and polyuria. A twelve hour urinary concentration test demonstrated an inability of the kidney to concentrate the urine above a specific gravity of 1.006. Evidence of marked renal insufficiency and "renal rickets" was demonstrated and a final diagnosis of bilateral polycystic disease of the kidney was made on the basis of characteristic radiologic changes noted in a retrograde pyelogram.

The subsequent course has been one of gradual deterioration of renal function.

(2) ANEMIA

In severe renal insufficiency anemia occasionally may predominate in the clinical picture, often leading to protracted, fruitless therapeutic efforts before renal disease is discovered as the underlying cause of the anemia. Any normocytic or microcytic, normochromic anemia, particularly when resistant to therapy, should raise the possibility of renal insufficiency and lead to urologic investigation.⁵

(3) GASTROINTESTINAL SYMPTOMS

Although the causes of chronic abdominal pain in childhood are legion, disorders of the genitourinary tract are among the most common causes of this complaint and no investigation of the chronic abdominal pain syndrome is complete without a thorough evaluation of the urinary tract. This indication for urologic investigation exists even though urinalysis is normal, since gastrointestinal symptoms may appear without either urinary changes or specific urinary symptoms.

Vomiting may be the presenting symptom, particularly in infancy, and may often focus at-

tention on the gastrointestinal tract before urologic disease is suspected. The following case history illustrates such a situation:

CASE REPORT

Case 2. This female infant was first hospitalized at the age of 4 months with the chief complaint of persistent vomiting since birth and failure to gain weight. Vomiting occurred regularly, immediately after each feeding. Bowel movements had been regular and stools had been normal. A number of gastrointestinal diagnoses had been considered, but previous x-ray studies had been normal.

At the time of admission the height and weight were below the third percentile, and urinalysis revealed a trace of albumin and a specific gravity persistently below 1.010. The abdomen was tense and a left lower quadrant mass was palpable. Intravenous pyelography demonstrated a large left hydroureter and hydronephrosis. Following surgical removal of the deformed structures there was complete relief from the presenting symptoms.

When last observed at the age of 3½ years she was entirely well, although small for her age.

(4) HYPERTENSION

Persistent hypertension is relatively rare in childhood. Its differential diagnosis includes hyperthyroidism, Cushing's syndrome, coarctation of the aorta, pheochromocytoma and chronic glomerulonephritis or chronic pyelonephritis. In addition to these causes unilateral renal disease secondary to an obstructive anomaly may be responsible for marked elevation of the blood pressure. Surgical removal of the affected kidney relieves the hypertension in 90 per cent of cases in childhood, in contrast to a less favorable experience in adult patients; hence it is extremely important to investigate the entire urinary tract when confronted with unexplained hypertension in children.⁶

(5) ENURESIS

This common complaint is due to functional causes in perhaps 95 per cent of cases. However, because of this fact, the remaining 5 per cent of patients in whom structural defects are responsible for the symptoms are all too often dismissed as emotional problems and denied urologic investigations until the development of secondary urinary symptoms suggests an anatomic defect.

Campbell repeatedly stresses the fact that enuretic children over the age of four years who have failed to respond to an adequate medical regime should be investigated from the urologic standpoint. In his experience, study of such a group of patients reveals structural anomalies which could account for enuresis in two thirds of the cases.

(6) URINATION DISTURBANCES

Dysuria, frequency, urgency or a poor or intermittent urinary stream would appear to be obvious indications for urologic investigations. It

is important to realize, however, that these symptoms may be extremely mild and may be unnoticed or disregarded by parents. Detailed questioning or actual observation of urination may be necessary before the facts become clear. All these symptoms are indicative of a partial obstruction below the level of the bladder and require prompt investigation. Sudden, extremely painful interruption of the stream is pathognomonic of bladder calculus, which produces this symptom by a ball-valve action.⁷

Since stenosis of the urethral meatus in *both* sexes is the commonest cause of these symptoms, simple inspection of the meatus may clarify the entire clinical picture. An additional simple maneuver is catheterization immediately following urination. Demonstration of residual urine usually is diagnostic of obstruction at or below the vesical neck. Lateral x-ray films taken during urination following introduction of radio-opaque dye into the bladder may demonstrate the exact site of obstruction. However, a complete urologic study of the upper urinary tract is indicated in these cases, as well as in more obvious anomalies of the external genitalia, since multiple anomalies are common.

(7) PYURIA AND HEMATURIA

Any obstructive anomaly of the urinary tract producing proximal distention with vascular congestion and secondary infection occasionally may cause bleeding. This is particularly true of hydronephrosis, where it may be the only symptom. Thus, any unexplained hematuria is a clear indication for thorough urologic investigation.

Since any obstructive urinary anomaly is commonly associated with recurring or chronic urinary infection, any persistent pyuria, any acute pyelonephritis recurring more than twice or any suspected chronic pyelonephritis are all indications for thorough urologic investigation. In connection with the diagnosis of chronic pyelonephritis, Stansfeld and Webb have recently emphasized the importance of quantitative pus cell counts in borderline cases, pointing out that pyuria may be slight and inconstant even in known cases of chronic pyelonephritis.⁸

(8) ABDOMINAL TUMOR

The most common abdominal tumors of infancy and childhood are embryoma of the kidney (Wilms tumor), neuroblastoma and hydronephrosis. All may be identified by intravenous pyelography, hence this procedure is mandatory in the presence of any abdominal tumor and should be carried out promptly in these cases.

SUMMARY

Obstructive anomalies of the genitourinary tract are common in infancy and childhood and may produce bizarre symptoms. The most misleading of these are growth retardation, anemia, gastrointestinal symptoms and hypertension.

Persistent enuresis, minimal disturbances of urination and minimal degree of pyuria or hematuria may all be the only evidence of potentially fatal urinary anomalies. Abdominal tumors in childhood are most frequently related to the kidney. All of these signs and symptoms, unless otherwise explained, are indications for thorough urologic study.

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The Administration of Anesthesia for Tonsillectomy and Adenoidectomy

Many children require tonsillectomy and adenoidectomy. I prefer to administer sufficient thiopental by rectum to put the patient to sleep while he is still in bed; this is generally accomplished with 0.2 cc. of a 10 per cent solution of thiopental sodium per pound of body weight. Thus, the patient is usually brought to the operating room asleep. Even if he is not asleep, he hardly ever will have any memory of the trip. As a rule, I anesthetize the patient with a nitrous oxide-oxygen mixture and ether, using an infant type of gas machine with a small breathing bag on it for a very small child or an adult type of gas machine with a small bag for a larger child. The child may be intubated with an intratracheal tube. The mouth gag is placed and the tube is connected to the breathing tubes of the gas machine.

The intratracheal tube usually is inserted through the mouth, but if tonsillectomy is to be done before adenoidectomy, the tube may be inserted through the nose. The adenoids can be removed with the tube in the nose since it generally will slide to one side or the other, but most surgeons prefer to have the tube in the mouth.

Use of the tube in the mouth is not too convenient for the anesthetist, but it can be managed. One of the difficulties, of course, is that the tube may kink or that it may be pulled out of the larynx and trachea. However, with practice the technique can be mastered so that the tip of the tube will not enter the right main bronchus and will not be pulled from the larynx. The endotracheal technique permits the surgeon to do a real job in most instances without respiratory obstruction and without aspiration of material into the trachea.—John S. Lundy, M.D., Rochester, Minn.: *Texas State J. Med.*, 51:809, December, 1955.

Franklin County Pelvic Cancer Delay Committee Report

By JOHN H. HOLZAEFFEL, M. D.

Columbus, Ohio, Chairman

The Franklin County Pelvic Cancer Delay Committee met on the third Wednesday of November at 12 o'clock noon. Two cases were presented.

Case 9: This 65 year old white female gravida III, Para III, first noticed symptoms of vaginal bleeding in October 1953. She immediately consulted her physician in Chicago where she then resided. He had her enter the hospital and on the 13th of October, 1953, he examined tissue taken for biopsy and coned the cervix. The microscopic examination revealed squamous cell carcinoma of the cervix. She then received 20 external treatments of x-ray. She did well until February, 1955, when a recurrence was noted. An additional 30 external treatments of x-ray were given.

The patient was seen at University Hospital on October 20, 1955. She was admitted to the hospital and biopsy specimen of the cervix was taken. The examination was reported as revealing poorly differentiated squamous cell carcinoma of the cervix. A cobalt implant was made. The patient had pulmonary symptoms of dyspnea and orthopnea develop on the 1st of November. She was readmitted to University Hospital. Thoracentesis yielded bloody fluid with malignant cells found on the spun-down specimen.

Comments: *Dr. Harry E. Ezell:* This case represents prompt reporting of symptoms by the patient, but delay in instituting adequate therapy by the physician. It is to be noted that no central therapy in the form of intracavitary irradiation was given to this patient.

Dr. O. Wildermuth: Our most single important weapon against cervical cancer is the central therapy.

Case 10: This 47 year old white female first noticed symptoms in July, 1955, when her "periods" began to occur every two weeks. She consulted her physician on October 14, 1955, at which time "fibroid" surgery was recommended. On October 18, 1955, a hysterectomy was done. The patient was seen in the Gynecology Tumor Clinic on November 11 with a recommendation that radiation therapy be carried out. An accompanying pathological report stated that the surgical specimen had an intact endometrium and Grade II epithelioma of the cervix.

Comments: *Dr. W. E. Crisp:* This case represents a situation wherein the patient's complaints were inadequately investigated. All facilities such as a papanicolaou smear, biopsy of cervix, and dilatation and curettage should be carried out before definitive surgery is contemplated. In this case, both tubes and ovaries were left behind.

Dr. O. Wildermuth: The radiologic treatment is complicated by incomplete surgery.

Dr. J. C. Ullery: This case represents not delay on the patient's or physician's part, but rather an inadequate and improper procedure from the surgical standpoint.



A Case Record

From The Lutheran Hospital,
Cleveland, Ohio

Edited Under the Auspices of the Ohio Society of Pathologists

Phillip Wassermann, M. D., President

Presented by Edmund F. Schroeder, M. D., and William Sinclair, Jr., M. D. Edited by Dr. Sinclair.

PRESENTATION OF CASE

THIS 56 year old white housewife was first admitted to Lutheran Hospital on March 21, 1952, for hysterectomy for large fibromyomas of the uterus which were said to cause menstrual irregularities. She was otherwise well except for a small inguinal hernia.

Preoperative laboratory studies which in retrospect are of interest are as follows: Total serum proteins, 7.2 grams per 100 cc.; albumin, 3.6 grams; globulin, 3.6 grams; A/G ratio, 1; blood urea nitrogen, 6 mgm. per 100 cc.; normal urea clearance; alkaline phosphatase, 5.4 units; serum cholesterol, 115 mgm. per 100 cc.; red blood count, 3.65 million; white blood count, 6,700; hemoglobin, 12.2 grams. Differential: 60 per cent neutrophils, 40 per cent lymphocytes. Kline serological test for syphilis was negative. X-ray studies of the gallbladder disclosed a pathologic gallbladder which did not respond to fat and did not contract. Barium examination of the upper gastrointestinal tract showed no evidence of organic disease. Barium enema x-ray studies demonstrated a normal colon.

A total hysterectomy, bilateral salpingo-oophorectomy, incidental appendectomy and repair of an accidental incision of a jejunal loop were done. The pathological report was fibromyomas of uterus, chronic cervicitis and fallopian tubes, ovaries and appendix, no pathological diagnosis. She was given two pints of compatible blood, Type A and Rh positive.

The postoperative course was stormy. The patient developed marked abdominal distention, oliguria, rising blood urea nitrogen (84 mgm. per 100 cc. highest recorded) and signs of early pneumonia. There had been no sustained or severe hypotension during surgery and there was no history of previous renal disease. Cystoscopy and retrograde pyelography disclosed no ureteral obstruction or lesions of the renal pelvis. Following vigorous fluid and antibiotic therapy, the patient improved during the second postoperative week, the blood urea nitrogen fell to normal and

the urinary output became adequate. Postoperative laboratory studies showed the alkaline phosphatase to rise from 5.4 to 8.8 units and the cephalin flocculation to be four plus. The patient was discharged in good condition on the 19th postoperative day and 27th hospital day.

HOSPITAL RE-ADMISSION

The patient was re-admitted for the second and final time on October 22, 1954, because of diarrhea of three months' duration. Bowel movements numbered six to seven times daily, were watery and devoid of blood or mucus and were accompanied occasionally by lower abdominal cramps. The patient had lost 18 pounds in weight during this period. Physical examination was essentially negative except for a slight edema of the legs and ankles. Temperature, 37 degrees Centigrade; pulse, 92 per minute; respirations, 26 per minute and blood pressure, 136/68.

ROENTGENOGRAPHIC EXAMINATION

A barium enema disclosed the colon to be hypotonic without specific pattern or haustration and was interpreted as typical of a colitis. Postevacuation films disclosed irregular areas of contraction and a peculiar folding of the colon with a ragged, irregular, saw-tooth outline involving the ascending colon, transverse colon and portions of the descending and sigmoid colon. The rectum and lower sigmoid were normal and this observation was important because the radiologist considered it to be against the diagnosis of ulcerative colitis. A repeat examination one month later showed no change. Small intestine studies with barium disclosed focal areas of dilated jejunum with an exaggeration of mucosal striations and flattening and periodic irregular constriction and narrowing of some small intestinal loops. The changes were nonspecific and interpreted as consistent with enteritis.

A chest x-ray showed the heart, lungs and aorta to be within normal limits. Skull x-rays were normal. X-ray studies of the gallbladder revealed changes consistent with chronic cholecystitis and cholelithiasis. Several electrocardi-

Submitted July 18, 1955.

ograms were normal. Repeat x-rays of the chest three weeks after admission showed signs of adhesions at the left base with obliteration of the left costophrenic sinus. This was interpreted as pleural inflammation. This change disappeared and in one month the chest x-ray was interpreted as negative.

LABORATORY FINDINGS

Over 500 laboratory tests were performed and only the most important are summarized. There was persistent moderate hypochromic anemia. Several white blood cell counts and differential counts were within normal limits. The sedimentation rate was always increased and reached 135 mm. per hour. The serum proteins varied somewhat and the A/G ratio was mostly reversed, averaging from 0.6 to 0.7, although ratios of 1 were obtained. The serum albumin ranged from 1.7 to 3.1 grams per 100 cc. and the serum globulin from 2.7 to 3.3 grams per 100 cc.

The urine (40 specimens) showed constant four plus albuminuria. The specific gravity ranged from 1.008 to 1.020. There was constant pyuria, 5 to 70 white blood cells per high power field and there were occasional hyaline and coarsely granular casts and red blood cells. Urine cultures showed growths of *Escherichia coli* and *Staphylococcus aureus*. The alkaline phosphatase ranged from 8 to 18 units. The C-reactive protein was four plus. Basal metabolic rate studies were plus 23 and plus 22. A Lupus erythematosus test for L.E. cells was negative. A biopsy of the gastrocnemius muscle was not remarkable.

The blood urea nitrogen rose from 12 mgm. to 90 mgm. per 100 cc. and there was lowering of urea clearance to 17 per cent and 46 per cent of normal. Bromsulfathalein excretion test (BSP) showed 8 per cent dye retained after 45 minutes. The thymol turbidity test was 2 units on several instances. The icterus index was 3 m. units. Serological tests for syphilis were negative. Agglutinins for typhoid, paratyphoid and brucellosis were negative. The stool was negative for ova and parasites on several occasions. Stool cultures were negative for pathogens. The serum sodium, potassium, calcium and phosphorus were within normal limits. A Congo red test showed 38 per cent of the dye to disappear in one hour.

Attempts at controlling the diarrhea were only partially successful with sulfasuxidine.[®] A chronic granulating ulcer was observed at sigmoidoscopy and swabs made from this were negative for amoeba. ACTH and cortisone were given in hope of alleviating the effects of the nephrotic syndrome but the patient developed severe side effects and these drugs had to be given intermittently. Large amounts of human albumin were given which gave temporary improvement. Two blood transfusions (500 cc. each) were performed and were uneventful. The patient was afebrile most of the time with only

slight variations in body temperature recorded. The blood pressure was not elevated at any time.

The last two weeks of her life were marked by severe weakness, dizziness, nausea, vomiting, apprehension and restlessness. The patient died on the 101st day of hospitalization.

CLINICAL DISCUSSION

DR. EDMUND F. SCHROEDER: In summary of this case then we have a 56 year old woman with laboratory evidence of liver disease, gastrointestinal disease, probably insignificant pulmonary disease, a moderate anemia and last and most prominent, severe renal disease.

First, in regard to the liver disease. Unfortunately not many liver function tests were done. The thymol turbidity was 2 units and the icteric index was normal but on her first admission there was evidence of marked impairment of liver function. There is certainly no history of dietary deficiency or alcoholism but we do know that she had long-standing gallbladder disease with stones. I believe Laennec's cirrhosis can be excluded. Obstructive biliary cirrhosis due to long-standing obstruction and infection in the biliary tract is a definite possibility.

In consideration of this patient's gastrointestinal disease, x-ray photographs and history pretty well rule out neoplasm. She seems to have some form of enterocolitis with a rather patchy involvement of both large and small intestine. I do not believe the roentgenograms are quite typical of ulcerative colitis and I believe it is most unusual to see the onset of chronic ulcerative colitis in a 56 year old patient without a previous history of colon symptoms. Also, we are told that her stools did not contain pus, blood or mucus, as usually seen in chronic ulcerative colitis. Infectious diarrheas, either amebic or bacillary dysentery should also be considered, but again the description of her illness does not fit either of these. Stool examination for parasites and cultures were all repeatedly negative. I am leaving her intestinal disease temporarily and will consider it later.

I do not think pulmonary disease played a very great part in this woman's illness. I believe she did have an inflammatory condition at the left base with pleural involvement; probably bronchopneumonia. However, this process apparently cleared and in the last chest film taken the lung fields were clear.

Renal disease is the major problem in this case. First, it was long-standing, as I think the postoperative course with a rise in blood urea nitrogen to 84 two and one-half years before her death indicated extensive renal damage at that time in spite of the paucity of urine findings. Secondly, it was nonhypertensive renal disease. Thirdly, after reviewing results of a host of urinalyses, I find heavy albuminuria the most constant finding. Pyuria was only slightly less

constant and hematuria and cylindruria were intermittent.

Arteriolar nephrosclerosis can be pretty well ruled out by the complete absence of blood pressure elevation.

Chronic glomerulonephritis usually causes more persistent hematuria and in the stage of renal failure usually shows blood pressure elevation, and changes in the fundi, etc., none of which our patient showed. The nephrotic stage of chronic glomerulonephritis also usually presents a different clinical picture. Here there is difficulty in formation as well as excessive loss of protein with resultant massive edema of face, hands and often the entire body, a picture which this patient apparently never presented.

Chronic pyelonephritis is a reasonably good possibility in this woman. While this disease usually causes at least mild hypertension, it may not elevate the blood pressure at all. She did have a positive urine culture for *E. coli* and had fairly consistent pyuria. However, it seems to me that the degree of albuminuria is much greater than is usually seen in chronic pyelonephritis and while I can't completely exclude mild coexistent pyelonephritis, I do not believe this to be her major renal disease.

Intercapillary glomerulosclerosis fits this picture very well in that these cases often have massive albuminuria as the only urinary finding for years prior to renal failure. While this disease has been reported in nondiabetics, it is usually secondary to diabetes mellitus. Most of these cases also have hypertension, often severe. I think Kimmelstiel-Wilson's disease unlikely.

Finally, in any case, with widespread involvement of several systems, we must consider the so-called "combined system diseases." Both disseminated lupus erythematosus and polyarteritis nodosa can cause severe renal disease with renal failure. Muscle biopsy and L. E. test, while both negative, certainly do not exclude these diseases. Usually with extensive renal involvement in these conditions there is hypertension, and in the stage of renal failure, this is marked. Also, both of these diseases almost always cause fever and this patient was for the most part afebrile.

Next, amyloidosis must be considered. As you know, there are three types. *Secondary amyloidosis* usually occurs in people who have some long-standing suppurative process and in chronic tuberculous infections. Amyloid is deposited in the liver, spleen and hemopoietic system and these people usually have tremendously large livers and spleens. In *primary amyloidosis* amyloid is precipitated in the mesenchymal tissues of the heart, blood vessels and gastrointestinal tract. This disease would fit this patient's picture very well but the main thing against this diagnosis is its rarity, only about 65 cases have been described to date. *Para-amyloidosis* is usually identified with multiple myeloma. Here the deposition

of amyloid is identical to primary amyloidosis; namely, gastrointestinal tract, mesenchymal tissues, blood vessels, etcetera. This certainly attracts me as the best explanation of this patient's clinical picture and I am going way out on a limb and say that this patient had para-amyloidosis.

Multiple myeloma would explain this patient's persistent, though not marked elevation of globulin. When multiple myeloma is accompanied by para-amyloidosis the elevation of the globulin is usually slight, which would be consistent with this woman's levels.

To make a diagnosis of multiple myeloma in the absence of any demonstrable bone lesion is very risky as bone lesions are said to occur in 92 per cent of all cases of multiple myeloma. However, Snapper, in his monograph on multiple myeloma found para-amyloidosis in 11 out of 44 cases, but of these 11, five had no demonstrable bone lesion. Therefore, when multiple myeloma is complicated by para-amyloidosis, the 8 per cent without bone lesion approaches 50 per cent. We certainly know that multiple myeloma can cause this renal picture with massive proteinuria and death in renal failure. Para-amyloid deposits in the intestinal tract could well explain her diarrhea and unusual x-ray picture.

I will rest my case with a diagnosis of multiple myeloma with para-amyloidosis.

CLINICAL DIAGNOSIS

Nephrosis.

Ulcerative colitis.

DR. SCHROEDER'S DIAGNOSIS

Multiple myeloma with para-amyloidosis.

PATHOLOGICAL DIAGNOSIS

Primary systemic amyloidosis.

Clear cell carcinoma, right kidney.

PATHOLOGICAL DISCUSSION

DR. WILLIAM SINCLAIR, JR.: I wish to compliment Dr. Schroeder on his fine analysis of this complicated case. There were some surprises at autopsy as you shall see and we will proceed directly to them.

The right kidney was the seat of a large primary clear cell carcinoma. (Fig. 1 and Fig. 2.) This was confined to the kidney and there were no metastases. In reviewing the various abdominal roentgenograms and pyelograms there is no evidence of this mass. There was no distortion of the pelvis or upper calyces as this tumor grew outward and superiorly. I feel this neoplasm was purely incidental and probably had nothing whatsoever to do with this patient's basic disease. If the patient had otherwise lived long enough, however, of course the carcinoma very likely would have spread and caused death.

The fundamental disease this patient had is primary systemic amyloidosis. By means of

routine hematoxylin and eosin staining methods and by producing the typical metachromatic reaction with special stains such as crystal violet following Lieb's technique,¹ we were able to demonstrate amyloid in the kidneys, liver, spleen, adrenals, small and large intestines, pancreas, heart, aorta and numerous lymph nodes. There was no evidence of multiple myeloma in the sections of the lumbar vertebra. There was no tuberculosis or chronic suppurative disease, such as osteomyelitis to explain this as secondary amyloidosis.

The distribution of amyloid in the kidneys, spleen and liver (slight) favors secondary amyloid

deposition but the presence in the other organs such as small and large intestine of course is rare and is more characteristic of the primary type. The tongue was not grossly remarkable and no sections were made from it. The tongue has been involved in various degree in 37 of 98 reported cases. Secondary amyloidosis has rarely been described in association with carcinoma and there is no apparent relationship.

We shall start our discussion of amyloidosis with the kidneys. The kidneys were similar except for the tumor on the right. The capsules stripped with ease and the surfaces were smooth, pale and yellowish-brown. The iodine and sul-



Fig. 1: Gross photograph of right kidney. Note large clear cell carcinoma arising from superior pole without appreciable distortion of pelvis. There were no clinical manifestations of this neoplasm.

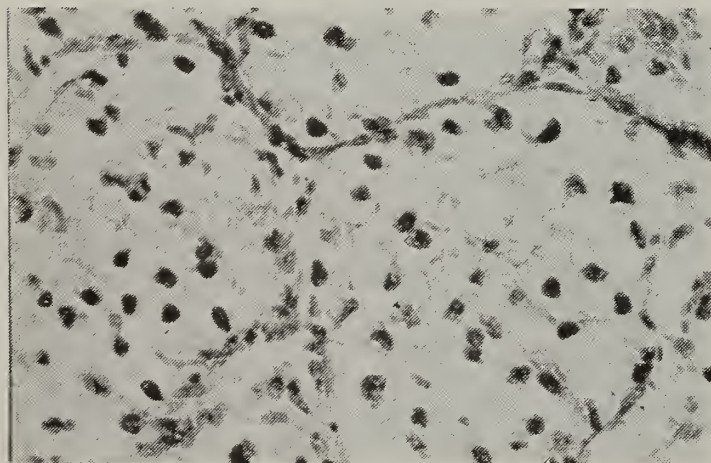


Fig. 2: Photomicrograph of kidney tumor in figure 1. Note typical clear cell carcinoma.

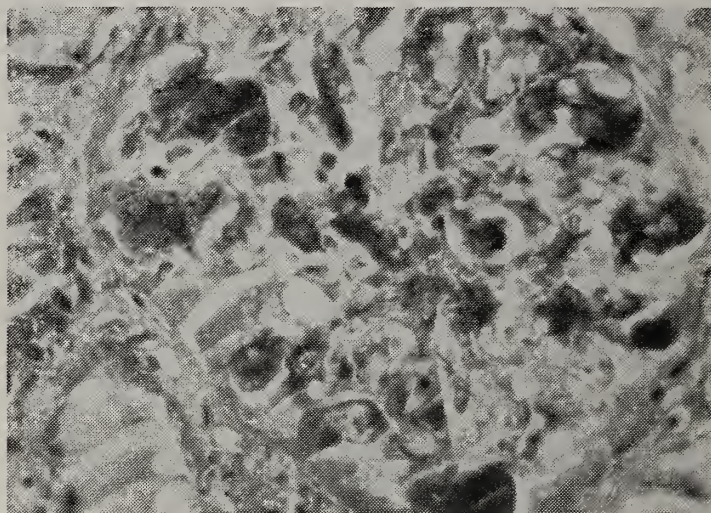


Fig. 3: Photomicrograph of single glomerulus. Crystal violet stain. The homogeneous dark masses in the glomerulus represent masses of amyloid. The lighter grey material in Bowman's space and in the tubules is protein which has leaked through the glomerulus.

furic acid test for amyloid was equivocal. Microscopic sections showed most of the glomeruli to contain abundant homogeneous acidophilic material which took the crystal violet stain. (Fig. 3.) There was amyloid in the small arterioles, especially in the cortico-medullary junctions. Most of the tubules contained abundant pink-staining

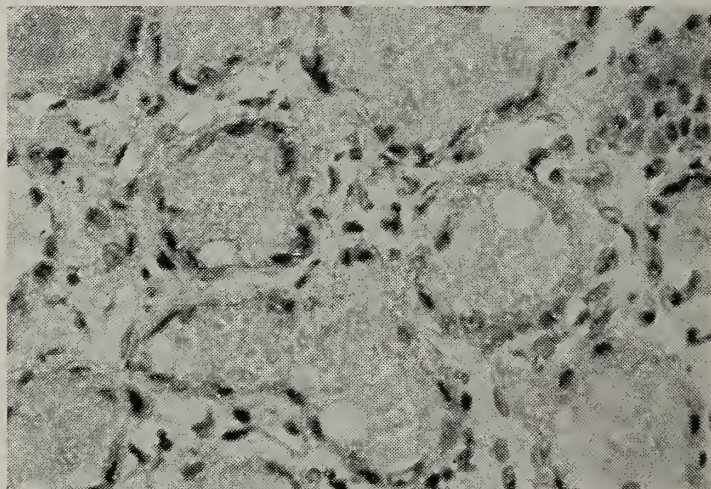


Fig. 4: Photomicrograph of renal tubules. The lumens are filled with protein material. This is a typical field.

protein material (Fig. 4) which represented protein which had leaked through the altered glomeruli and which, of course, accounts for the constant massive proteinuria. In addition, there was interstitial infiltration of the kidney with

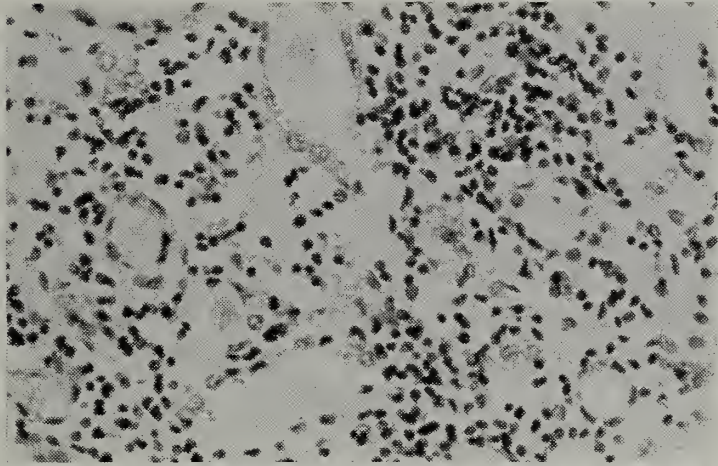


Fig. 5: Photomicrograph of kidney. Interstitial infiltration with lymphocytes. Tubules contain protein casts.

lymphocytes. (Fig. 5.) The clinical changes in the urine and blood are thus well explained by these changes in the kidneys.

The spleen was a typical "sago" spleen. There were abundant widespread, fairly well defined deposits of amyloid in the follicles as demonstrated with hemotoxylin and eosin stains as well as

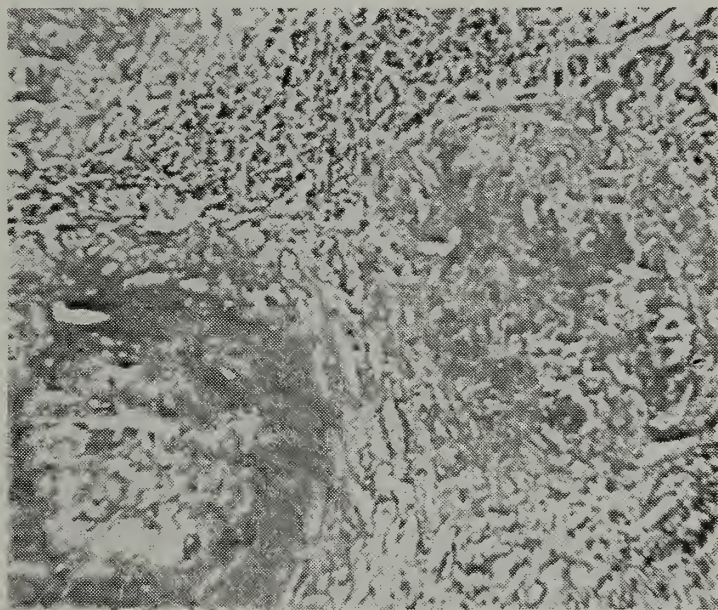


Fig. 6: Photomicrograph of spleen. Crystal violet stain. Well defined masses of amyloid typical of "sago" spleen.

crystal violet stain. (Fig. 6.) The spleen weighed 310 grams which is about twice normal.

The liver contained only small amounts of amyloid and this was found in the sinusoids between the endothelial cells of the sinusoids and parenchymal cells. The liver weighed 2060 grams which is about 25 per cent above normal. The relatively normal "liver function tests" reflect this minimal change. The adrenals also were infiltrated with small amounts of amyloid.

The ulcerations and alterations observed in the roentgenograms of the small intestine and colon described in the protocol are explained by the deposition of amyloid in the mucosa, muscularis mucosa and bases of the ulcers and infiltration of the arterioles and small arteries and veins with amyloid. Figure 7 represents such an ulcer of the colon. There were many similar small ulcers throughout the small and large in-

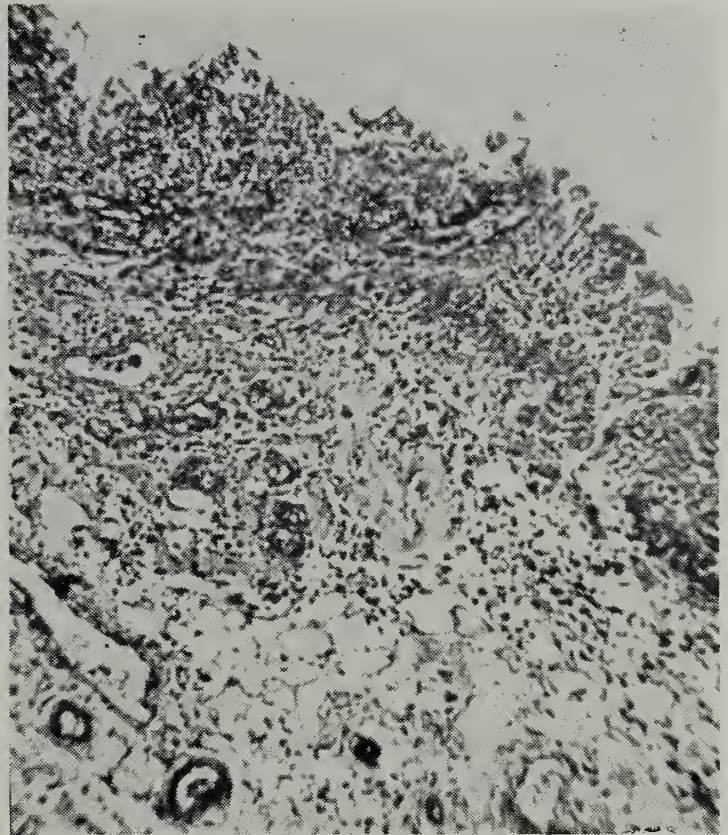


Fig. 7: Photomicrograph of colon. There is ulceration of mucosa and infiltration of submucosa with lymphocytes. The dark staining masses in the base of the ulcer and in the walls of the arterioles and veins are amyloid. Crystal violet stain.

testine. No other cause is apparent. Ulceration due to amyloidosis has been described previously in the literature.¹

The interstitial tissues of the myocardium of the left ventricle of the heart showed small amounts of amyloid. The heart weighed only 260 grams (normal size). The normal electrocardiograms correlated well with the small amounts of amyloid present which were probably insufficient to produce changes. Heart failure has been a presenting sign in some reported cases with massive myocardial infiltration. In addition, there was amyloid in the media and serosa of the aorta, in the interstitial tissues of the pancreas and in the thoracic and abdominal lymph node groups. These deposits probably did not produce any significant clinical manifestations.

There was no foreign body type giant cell reaction about any of the deposits of amyloid. This reaction is sometimes observed in primary amyloidosis, but is uncommon in the secondary form.

The diagnosis of primary amyloidosis is based on the microscopic identification of amyloid in various organs in the absence of tuberculosis, chronic suppurative disease such as osteomyelitis, other chronic diseases and multiple myeloma. Approximately 98 cases have been recorded in the literature, although the exact number is not known due to variations in classification and reporting. The disease is probably more common and simply is not recognized. The presenting clinical manifestations may be related to any of the organ systems involved. The diagnosis is

rarely made at the clinical level and is essentially one of exclusion of everything else and then being aware of the possibility of amyloidosis. Cardiac failure, renal failure, enlargement of liver or spleen or lymph nodes or macroglossia may be the first clues.

Knowledge of the nature and pathogenesis of amyloidosis is limited. There are many theories, none of which is well accepted. Those of you who are interested in the subject are referred to an excellent review article by Mathews² who is Assistant Professor of Pathology at McGill University. There is a fine bibliography of 77 references.

GENERAL DISCUSSION

DR. MILTON BOBEY: How do you account for the Congo red test of 38 per cent?

DR. SINCLAIR: This test is at the upper limits of normal. However, to be diagnostic, 85 to 90 per cent or more of the dye should disappear from the blood. The dye is picked up by the amyloid deposits in the body and remains there. Some cases show positive tests (disappearance of injected dye); others do not. There is no satisfactory explanation for this variation. Like so many tests, it is most useful when positive.

DR. MAIER DRIVER: Is there any treatment for amyloidosis?

DR. SINCLAIR: There is no specific treatment for this condition. It is of great interest that spontaneous regression of amyloid infiltration has been reported in cases of osseous tuberculosis with amyloidosis and also in amyloidosis occurring in animals following experimental production with bacteria and sodium caseinate. There is always a possibility that spontaneous regression might occur in systemic amyloidosis, but this is admittedly slight, according to our present knowledge.

DR. MYRON AUGUST: How long did this patient have amyloidosis? Do you consider it likely that it was present at the time of her first admission?

DR. SINCLAIR: It is impossible to state with any accuracy when this process started. This disease has a slow insidious onset and occurs chiefly in the middle age group. As Dr. Schroeder mentioned in his discussion, it is apparent that this patient had at least subclinical renal disease at the time of her first admission as evidenced by the acute renal failure at the time of surgery. She simply couldn't handle the extra load but was able to get along satisfactorily otherwise. I suspect that she had some amyloid infiltrate in her kidneys at that time but I cannot prove it. I have gone over the microscopic sections from the surgical specimens removed in 1952 (uterus, tubes and ovaries) and am unable to detect amyloid in them. In addition, we recut the paraffin blocks and made crystal violet prep-

arations and these are negative for amyloid. This does not exclude deposition in the kidneys, though, at that time.

REFERENCES

1. Lieb, Ethel: Permanent Stain for Amyloid. *Am. J. Clin. Path.*, 17:413-414, 1947.
2. Mathews, W. H.: Primary Systemic Amyloidosis. *Am. J. Med. Sc.*, 228:317-333, 1954.

Postnasal Saline Pack Following Adenoidectomy

By H. M. AMSTUTZ, M. D.*

The recognition of the important relationship between adenoid hypertrophy and deafness in children has contributed toward the performing of more careful and sometimes more extensive adenoidectomies with a consequent increase in the possibility of postoperative hemorrhage from the adenoid area.

Numerous variations of postnasal packing with gauze to control annoying and sometimes dangerous hemorrhage following adenoidectomy have been described. All these methods are aggravating to young patients who can scarcely be expected to understand the reason for this ordeal and who do not appreciate further manipulation either in placing or removing gauze packing from the nasopharynx after adenoidectomy. For several years I have attempted to avoid all such procedures by using a postnasal or adenoid "pack" of normal saline infiltrated into the upper lateral nasopharyngeal tissues at the time of operation.

METHOD

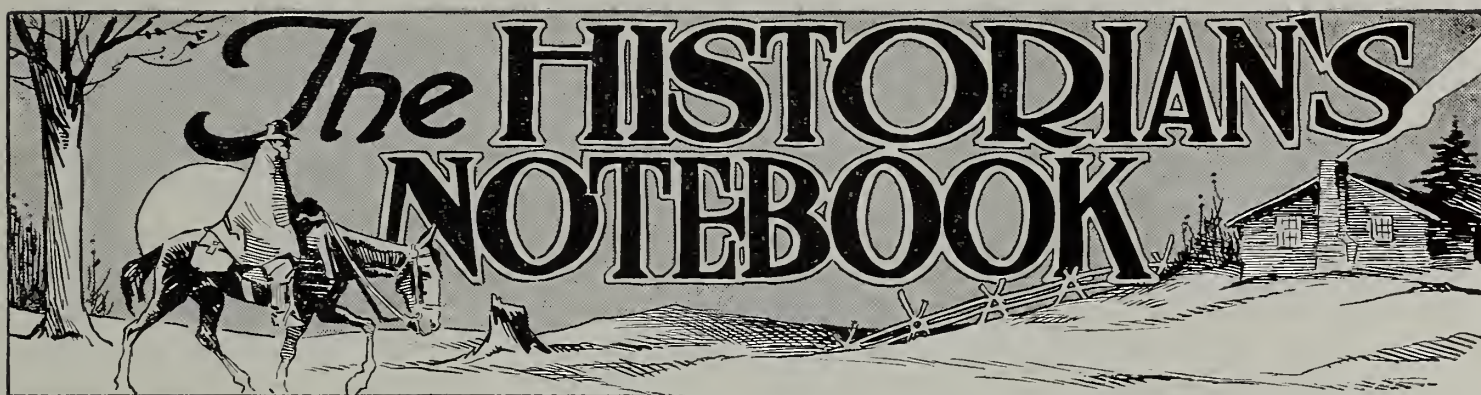
In an adenotonsillectomy the adenoids are removed first and gauze packing placed in the nasopharynx while the tonsils are removed and complete hemostasis of the tonsillar fossae attained. Then the nasopharyngeal gauze packing is removed and the adenoid region carefully inspected for signs of hemorrhage. If hemorrhage is observed, about two or three cubic centimeters of normal saline is infiltrated into the lateral portion of the area as high as possible on each side. This amount will stop most hemorrhage promptly. Occasionally it is necessary to make a second injection of saline.

COMMENT

This simple procedure has made the use of postnasal gauze packing almost totally unnecessary postoperatively. The saline is quickly absorbed, nasal breathing is usually maintained postoperatively and in most cases the formation of an obstructive postnasal clot is obviated. During the past six years there have been no complications of any kind following this procedure.

*Dr. Amstutz, Lancaster, former instructor in anatomy, and former instructor in otolaryngology, The Ohio State University College of Medicine, is a member of the Board of Governors, Lancaster-Fairfield Hospital.

Submitted August 24, 1955.



The Northside Medical Research Society: 1908*

JONATHAN FORMAN, M. D.

ON March 9, 1908, there met in the office of A. Clovis Taylor, M. D., a group of 22 physicians practicing north of the viaduct in Columbus, Ohio. A. C. Wolfe was elected chairman and Darlington J. Snyder secretary of the meeting.

"Dr. Wolfe stated that the object of the meeting was to discuss a uniform fee bill and the credit rating of the people on the Northside. He suggested that a fee of \$1.50 be made the minimum for a house visit; whereupon Dr. Beatman asked the chair for the limits, to which Dr. Wolfe replied: 'from \$1.50 to \$5.00, graded according to the distance and to day or night visits.' He also said obstetrical fees should be from \$15.00 and up. Dr. J. H. McClure stated that a fee of from \$2.00 to \$4.00 was working well in Washington D. C., and that he was charging \$1.50 for house visits.

"Dr. E. G. Horton stated in most emphatic words that no physician should make *one* dollar house calls. Dr. Clovis Taylor then declared, 'Columbus has the cheapest Doctor's services in the United States. I make this statement after full deliberation based on thorough comparative research.' He said that fees for short distances should be eliminated and \$2.00 be the minimum for day calls and \$5.00 for night calls. '\$1.50 per call is surely not getting out of the rut.'

"Dr. A. C. Howell said, 'It is not the fee alone—not the fifty cents, not the one dollar—but physicians must take a business-like attitude towards the individuals and the families whom they serve, and, like business men, promptly and accurately render their bills monthly. This matter of small fees and poor collections is largely the physician's own fault. The smallest fee should be \$2.00. Telephone advice should be \$1.00. A practitioner who will charge 50 cents for a lung and heart examination does not know

The Author

● Dr. Forman, Columbus, is Professor of the History of Medicine in The Ohio State University.

his business. Obstetric fees should be from \$20.00 to \$50.00.' He recalled a case of 'Colles' fracture' on which the professional fee was a charge of \$10.00. Subsequent examination of the injury disclosed that the fracture had not been reduced.

"Dr. Howell further presented the argument that in obstetrical cases, the practice of making allowances for young married couples not only contributes to the prodigality on the part of the people whom we serve but cheapens the professional services. 'The parties know about the coming event nine months before it occurs. If they would lay aside \$2.00 per week, there would be a saving of \$72.00. Allowing \$20.00 for professional services, \$30.00 for efficient nursing, \$14.00 for domestic services, there would still be \$8.00 for contingencies.'

"Dr. Green urged prompt collection every 30 days. As to fees, he said: '\$2.00 should be the minimum.' Dr. Courtright insisted it is impossible to have one and the same fee. He charged from \$15.00 to \$25.00 for obstetrical services and office calls from \$1.00 to \$2.00. 'I collect my bills; I do not have more than \$100.00 on my books.'

"Dr. Townson declared that we physicians are very illy protected since the patient can go from office to office to get cheaper service. 'There must be general uniformity. The doctors themselves pauperize the profession. There should be a dead-beat list; all of those on it should be referred to the city physician.'

"Dr. Clark declared it was evident that the

*I have recently had access to the minute book of this society of nearly 50 years ago. The subjects discussed and the viewpoints expressed give such a clear insight into the status of medical practice of two generations ago that they seem worthy of publication as valuable source material.

Northside physicians needed a permanent organization.

"Dr. Clovis Taylor, after due absorption and reflection on the evening's discussion, sprung a very timely and conservative precaution relative to a permanent organization. Such an organization, he said, might create the impression that we are forming a union to advance prices and suggested legal advice on the matter. He referred to the Ice Trust and the punishment by the court and painted a picture that foreshadowed the gloomy walls of a very unsavory place.

"Dr. Howell, unalarmed by the tocsin of legal danger, answered Dr. Taylor by saying that ice is a commodity, while the physician's stock in trade is his skill. One very pleasant event of the evening was the presence of our friend and co-laborer, Dr. W. S. Van Fossen, who spoke on the comparative value of a physician's services.

"On motion, the president was authorized to appoint the following committees: (1) on Fee Bill; (2) Credit Policy List; (3) on Permanent Organization.

MARCH 16, 1908

"The next meeting was held one week later in the office of Clovis Taylor. Dr. Earl Evans, chairman of the Committee on Fee Bill, reported that in the committee's opinion:

"Day calls should be from \$1.50 and up;

"Night calls should be from \$2.50 and up;

"Consultation should be from \$5.00 and up;

"Obstetrics should be from \$15.00 and up;

"Office visits should be from 75¢ and up.

"Then there followed a discussion concerning giving advice over the telephone. Dr. C. A. Howell said no people are as quickly educated as the American people. By the telephone system of advising patients for 50 cents, the physicians would greatly diminish their practices. The patient will argue, 'I can do better by telephoning at 50 cents than by going to the doctor's office for 75 cents or a dollar.'

"'You are in the midst of an examination of the heart, lungs, or other vital organ when the telephone calls you from your work; the continuity of detail is broken and, thereafter, effective sense is impossible. But the telephone charge at one dollar. Your office is the place to transact business—not over the telephone.

"'A telephone call comes like this: "Doctor, must I have the last prescription re-filled?" Your answer is "Yes," or "No." For this there should be a charge of one dollar. I don't keep medicine, I write prescriptions myself,' declared Dr. Howell.

"Dr. Ralph Taylor expressed the idea that this is a small matter to discuss. 'I never write prescriptions,' said Dr. Ralph. 'To Dr. Howell, who has a large and lucrative practice, a telephone ring would be annoying but to us who have a smaller practice, a telephone ring is

very acceptable. I rather enjoy it. From my point of view, conservatism in office charges is the better.'

"Dr. Green expressed his dislike of a fee bill tacked up in the office. He thought it not only was not necessary but that it was inviting the disfavor of our patients. He also warned against some of the dangerous phases of the use of the telephone—The physician is told that he is to return a telephone call. He forgets. The patient feels hurt or neglected. You can't explain it away.

"On motion by Dr. Horton the telephone item was omitted from the list for the present.

"Dr. Inglis said he favored \$1.00 office calls and 50 cent telephone charge. 'If the people are told about it,' he thought, 'it would reduce their annoyance.' After additional remarks by Drs. Horton, Townson, Nieswander, Starr, Clovis Taylor, W. D. Inglis, and Earl Evans, the matter of a fee bill was postponed to a future date.

"The Committee on Permanent Organization, consisting of Drs. Howell, Taylor, Wolfe, Riebel, and Snyder, presented the following resolution:

"The members of your committee believing that to organize a Northside Medical Association would in no way be derogatory to the life and growth, but on the contrary, be promotive of and contributory to the interests of the Columbus Academy of Medicine, resolved to recommend a permanent organization of the physicians north of the viaduct.

"Whereupon the committee prescribed for adoption a constitution and by-laws, setting forth the purpose and objectives of the society as: To furnish opportunities and facilities for medical research, to promote sympathetic brotherhood of the medical profession, to elevate social and true ethical relationship, to sustain appreciative values of professional services and to cultivate an altruistic spirit of mutual helpfulness.

"The committee report on proposed constitution and by-laws was adopted. The first officers were: A. C. Wolfe, president; J. F. Jones, first vice-president; Ralph Taylor, second vice-president; Earl Evans, treasurer; Darlington J. Snyder, secretary.

"On March 25th, the Society met upon invitation of J. F. Jones at the Northern Hotel. Ninety-one hungry physicians surrounded the festal board, well loaded with the good viands that appealed graciously to appetites already sharpened for the occasion. Dr. J. F. Jones was appointed toastmaster. Acting in a gracious and witty manner, he added much to the evening.

"After the speeches, President Wolfe resumed the chair. On motion of Dr. Charles Means, a vote of thanks was extended to Dr. J. F. Jones and Mr. W. E. Kinney of the Northern Hotel for the hospitality of the evening. Mr. Kinney

extended an invitation to hold future meetings of the Society at the Northern Hotel. The invitation was accepted.

"At the meeting of April 8th, upon motion of Dr. Cleveland, the fee bill originally submitted by Dr. Evans' committee was adopted unanimously.

"The report of the Committee on Credit Rating follows:

"Plan 1. Each physician to become a subscriber to one of the credit rating agencies at the cost of \$1.00 per year. Each subscriber receiving the Year Book giving the rating of the people of Columbus and vicinity, as determined by the way in which these people have paid their debts to local merchants. A weekly supplement is also issued. Additional information may also be had by telephone with the office of the agency.

"Plan 2. Each physician is to submit a list of those who do a credit business, marking each name with the appropriate rating as per the following scheme:

P. Prompt pay	R. Have refused to call
S. Slow pay	X. Cannot recommend for credit

These ratings by the individual physicians will be sent to a central office or stenographer, there to be compiled alphabetically. A full list, printed or typewritten, sent to each contributing physician—supplementary list to be sent out each month. The cost shall be divided equally among the physicians participating.

"The committee recommended the second plan and urged that its existence be kept quiet. While it is perfectly legal and honorable, it is apt to be misunderstood and the physician maligned by those who may perchance hear distorted reports of the plan.

"The report was received and placed on record."

(To be continued)

An Historical Chronology of Tuberculosis, by Richard M. Burke, M. D., (\$3.75. Second Edition. Charles C. Thomas, Publishers, Springfield, Ill.). This work is an attempt to convey very briefly the story of tuberculosis. The author has divided the subject into three periods: The Ancient Period to 1600 A. D., largely descriptive; Pre-Modern Period 1600-1800, physicians began to examine the dead; the Modern Period 1800-1881, (Part I) the establishment of the unity, and specifically of the tubercle; The Modern Period (Part II), 1882-1954, the discovery of the germ, improved diagnosis with x-ray, improved surgery and new drugs.

West to Ohio, by Alta Harvey Heiser, (\$3.00. The Antioch Press, Yellow Springs, Ohio). A book which helps to lay the foundation for a definitive history of the Great Miami Valley that is yet to be written. It is therefore a book which every physician who lives in that valley will want to read and own as will all of us who are interested in the history of our State.

The Story Behind the Word

Some Interesting Origins of Medical Terms

Abscess—Derived from the Latin word "abscessus," meaning "gone away" or "departed," this term is composed of the Latin words "ab" or from, plus "cedo"—I go. Hence an "abscess" is figuratively a little hollow where the flesh has gone away and pus has formed.

Psittacosis—This disease is also called Parrot Fever and derives its name from the Greek word "psittakos," or parrot. It is a virus disease of birds and secondarily infects man through contact with parrots and parrakeets. The disease was first described by Jacob Ritter as an outbreak of "pneumo-typhus" in 1879 at Uster, Switzerland. Nocard, a French veterinarian, isolated the organism in 1893. The name "psittacosis" was given to the disease by Morange in 1895.

Psoas—This ancient Greek word designating the loins was used in various forms by Hippocrates to refer to the loins. Galen also used this term to refer to the muscles of the loins. In 1610 Jean Riolan, a French anatomist, introduced the spelling "psoas" and accurately described the psoas major and minor muscles.

Profane—Coming from the Latin "pro" or before and "Fannum" or temple, this term literally means being "before or outside of the temple," hence applied to those who stood before or outside of the temple because they refused to come in and accept the teaching. Thus by extension the term came to apply in the sense of treating sacred things with contempt and also to mean sacrilegious talk or swearing.

Priapism—A condition characterized by an abnormal persistent erection of the penis. Paul of Aegina wrote of this condition and used the term in the seventh century. The condition receives its name from either Priapus or Priam. Priapus was the Greek God of gardens and reproduction. He was the son of Aphrodite and Dionysus and was represented by a red painted figure with a club or garden knife and having a large phallus, symbolic of his procreative powers. Priam, according to Greek legend was the last king of Troy and was renowned as the father of 50 sons and 50 daughters.

Potter's Field—This term comes from the Bible (Matthew, XXVII:7) and was the free burial place bought with the 30 pieces of silver Judas threw away before killing himself. It was called "Potter's Field" because it was once a field from whence the potters drew their clay and the soil supposedly rapidly decomposed the bodies. The term thus came to refer to any free burial ground.

—HARRY WAIN, M. D., Mansfield, Ohio.



**Make Yourself a Part of the
1956 ANNUAL MEETING
Picture, Doctor.**

The Place: Cleveland

The Dates: April 10, 11 & 12

The accompanying pictures were taken at last year's Annual Meeting in Cincinnati. Perhaps you are in one of them; or, perhaps you were out of camera range but were one of the more than 1,500 physicians who attended.

*Plan now to make yourself part of the
1956 Annual Meeting.*

Resumé of the 1956 Annual Meeting Program

Ohio State Medical Association, Cleveland

(Events at Cleveland Public Auditorium, unless otherwise indicated)

MONDAY, APRIL 9

Ohio State Heart Association: Hotel Statler, 9:00 a. m. to 4:30 p. m.

Cleveland Society of Obstetrics and Gynecology: Social Hour and Dinner, University Club.

TUESDAY, APRIL 10

Specialty Section Programs: (10:00 a. m. to 12:30 p. m.)

- Joint Session, Section on Anesthesiology and Section on Pediatrics:

(2:00 to 5:00 p. m.)

- Joint Session, Section on General Practice and Section on Surgery:
- Section on Nervous and Mental Diseases:
- Section on Ophthalmology.

Specialty Society Meetings: (10:00 a. m. to 12:30 p. m.)

- Ohio Academy of General Practice.
- Ohio Chapter, American College of Chest Physicians.

(2:00 to 5:00 p. m.)

- Ohio Society of Anesthesiologists.
- Ohio Chapter, American Academy of Pediatrics.

Medical Motion Pictures: 2:00 to 4:00 p. m.

House of Delegates, First Session: Hotel Statler, 5:00 p. m.; dinner 7:30 p. m.

WEDNESDAY, APRIL 11

Specialty Section Programs: (9:30 a. m. to 12:30 p. m.)

- Joint Session, Section on Neurosurgery and Section on Radiology.
- Section on Obstetrics and Gynecology.
- Section on Physical Medicine.

Specialty Society Meeting:

- Ohio Psychiatric Association: 9:30 a. m., continuing into afternoon.

Medical Motion Pictures: 10:00 a. m. to 12:00 noon.

Seminar on Medical Writing: 10:00 a. m. to 12:00 noon.

General Session: 2:00 to 5:00 p. m.

Annual Banquet: Hotel Statler, 7:30 p. m.

THURSDAY, APRIL 12

General Session: 10:00 a. m. to 12:30 p. m.

Specialty Section Programs: (2:00 to 5:00 p. m.)

- Section on Internal Medicine.
- Section on Otorhinolaryngology.
- Section on Urology.

Medical Motion Pictures: 2:00 to 4:00 p. m.

House of Delegates, Second Session: Hotel Statler, 1:00 p. m.

The Scientific and Educational Exhibit and the Technical Exhibit will be open daily for frequent visits.

Guest Speakers, 1956 Annual Meeting . . .

Here Are Eight Out-of-State Physicians, Each an Authority in His Field. Who Will Add Much to the Program in Cleveland, April 10-12

THE Ohio State Medical Association has been fortunate in securing eight out-of-state guest speakers for the Annual Meeting program in Cleveland, April 10, 11 and 12. The following brief sketch of each is given merely to identify the guest, to indicate his field of work and the subject or subjects on which he will talk.

Ohio physicians who wish to hear any one of them speak is invited to do so, whether the occasion is a General Session or a Specialty Section program. All Specialty Section meetings are open to physicians in good standing with the Association regardless of branch of practice.

These are the guest speakers and the topics on which they will talk:

Curtis P. Artz, Lt. Col., MC, USA; Brooks Army Medical Center, San Antonio, Texas; graduate of Ohio State University College of Medicine, 1939; diplomate of the American Board of Surgery; Fellow of the American College of Surgeons; assistant clinical professor of surgery, Baylor University College of Medicine, Houston; chief of the Research Section, Medical Field Service School, Fort Sam Houston.

"Treatment of Burns" will be the subject of his talk before the joint session of the Section on General Practice and Section on Surgery, Tuesday afternoon, April 10.

Carl E. Badgley, M.D., professor of surgery, University of Michigan Medical School; graduate of the University of Michigan, 1919; diplomate of the American Board of Orthopedic Surgery; member of the American Orthopedic Association, American Surgical Association, the Clinical Orthopedic Society, the American Academy of Orthopedic Surgeons, and Fellow of the American College of Surgeons.

"Chronic Back Pain," will be the subject of Dr. Badgley's talk before the joint session of the Section on General Practice and Section on Surgery Tuesday afternoon.

Hermann Burian, M.D., associate professor of ophthalmology, University of Iowa Medical School; medical diploma from the University of Belgrade, Yugoslavia, 1930; diplomate of the American Board of Ophthalmology; member of the American Academy of Ophthalmology and Oto-Laryngology, the Association for Research in Ophthalmology and the New England Ophthalmological Society.

Dr. Burian will speak before the Section on

Ophthalmology on Tuesday afternoon on the subject, "Problems in Diagnosis and Treatment of Strabismus."

Edgar Burns, M.D., professor of urology, Tulane University, New Orleans; graduate of Northwestern University Medical School, 1923; diplomate of the American Board of Urology; member of the Southern Surgical Association, the Southeastern Surgical Congress, the American Association of Genito-Urinary Surgeons, the American Urological Association, the Clinical Society of Genito-Urinary Surgeons, and Fellow of the American College of Surgeons.

Dr. Burns will take a leading role in the program of the Section on Urology on Thursday afternoon. He will speak on the subject, "Problems Involved in the Management of Bladder Neck Obstruction in Children," and will be moderator of a panel discussion on the subject, "Pyelograms."

D. Ewen Cameron, M.D., director of the Allen Memorial Institute of Psychiatry, Montreal, Canada; graduate of the University of Glasgow Medical Faculty, 1924; diplomate of the American Board of Psychiatry and Neurology; member of the American Psychiatric Association, Association of Research in Nervous and Mental Diseases, American Association of Industrial Physicians and Surgeons; professor of psychiatry at McGill University.

Dr. Cameron will speak before the Section on Nervous and Mental Diseases on Tuesday afternoon—subject to be announced.

Julian Johnson, M.D., professor of surgery at Pennsylvania School of Medicine and graduate of the same school, 1931; diplomate of the American Board of Surgery; member of the American Surgical Association, American College of Surgeons, Society of Clinical Surgery, Society of University Surgeons, American Association of Thoracic Surgery.

Dr. Johnson will speak on "Injuries of the Chest," before joint session of the Section on General Practice and the Section on Surgery on Tuesday afternoon.

Morton Marks, M.D., Institute of Physical Medicine and Rehabilitation, New York University and Bellevue Medical Center, New York; graduate of Temple University School of Medicine, 1943; diplomate of the American Board of Psychiatry and Neurology; assistant professor of clinical neurology, NYU; member of the American Academy of Neurology, American Psy-

**PRINT OR TYPE YOUR NAME UNDER SIGNATURE ON
ALL WORKMEN'S COMPENSATION FORMS**

A considerable number of Workmen's Compensation Forms, C-3 and C-19, involving fee bills submitted by physicians, have been stacked up in the Claims Department of the Bureau of Workmen's Compensation and cannot be put through for payment because the signatures of the physicians cannot be deciphered.

The officials of the Claims Department emphatically urge physicians in signing all Workmen's Compensation forms to type or stamp their name under their legal signature to enable the department to quickly ascertain the name of the signing physician. The department does not have sufficient personnel to undertake the correspondence which will be necessary to straighten out these "unknowns."

Physicians want to be paid promptly. The department wants to pay them promptly. This objective can be achieved more readily if physicians will make sure that their names are typed or printed on each blank near the place where their legal signature appears.

chiatric Association, American Federation of Clinical Research.

Dr. Marks will participate in two sessions. On Wednesday morning he will speak before the Section on Physical Medicine on the subject, "Recent Advances in the Diagnosis and Treatment of Neurological Diseases," and on Wednesday afternoon he will address a General Session audience on the subject, "Rehabilitation of the Hemiplegic Patient."

Donald L. McRae, M. D., Montreal Neurological Institute of Montreal, Canada; graduate of the University of Western Ontario Faculty of Medicine, 1938; diplomate of the American Board of Radiology; member of the American College of Radiology and the Canadian Association of Radiologists; assistant professor of neurology and neurosurgery, McGill University.

"The Significance of Bony Abnormalities About the Foramen Magnum" and "The Scope and Value of Radiological Diagnosis in Cerebral Vascular Accidents" are the subject of two talks by Dr. McRae, the first before the joint session of the Section on Neurosurgery and the Section on Radiology on Wednesday morning, and the second before the General Session on Wednesday afternoon.

Pennsylvania G. P. Meeting

The Pennsylvania Academy of General Practice has announced its eighth annual convention to be held at Bedford Springs, Pa., May 18-20. The meeting will combine a scientific session with planned and organized activities for wives and children. Additional information may be obtained from the academy at 27 Baltimore St., Mt. Holly Springs, Pennsylvania.

Large Endowments Announced For Western Reserve

A gift of \$1,000,000 for the endowment of the Western Reserve University School of Medicine was announced late in December by trustees of the Hanna Fund.

The gift was made to equal another million dollars which the Commonwealth Fund of New York offered the school with the proviso that the sum be matched locally.

The present grant of \$1 million by the Commonwealth Fund will bring to approximately \$2,800,000 the amount which this philanthropic organization has contributed to support the school and its new curriculum for medical education.

The Associated Press reported that Dr. John S. Millis, president of Western Reserve University, was notified of the action of the Hanna Fund trustees through a letter which stated that the Commonwealth Fund's offer was convincing appraisal of the high standing which the medical school had attained under Dean Joseph T. Wearn.

Dr. Wearn reported that the medical school still depends on annual gifts for about one-third of its budget and that the grants would substantially strengthen the school's endowment fund. In 1929 Western Reserve University received 95 per cent of its income from student fees and endowment and 5 per cent from annual gifts.

The Ford Foundation has announced that it will divide \$90 million among the country's medical schools. Approximately 40 of the nation's medical schools are privately operated and, according to previous announcements, these are the ones that will share in the Ford Foundation gifts.



Calendar Note

Dates: April 10, 11 & 12

Place: Cleveland

Above is the time and place of the
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STATE MEDICAL ASSOCIATION. Please
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What's New in Congress . . .

Important Medical-Health Measures Scheduled for Action; Bill Calling For Medical Care for Military Dependents Analyzed in Detail

SECOND session of the Eighty-Fourth Congress opened on January 3 in an election-charged year that promises considerable activity in the medical-health field.

President Eisenhower's State of the Union Message calls for an increase in federal funds to support medical research, federal construction grants for medical schools and research facilities, and the extension of voluntary health insurance to "many more persons." The President's health program was only briefly outlined in this document; it will be presented in detail in a special health message later.

To aid in "cushioning the heavy and rising costs of illness and hospitalization to individuals and families," the President calls on Congress to promote extension of voluntary health insurance to "many more persons," especially older persons and those in rural areas, this to be accomplished "by Federal reinsurance or otherwise." He also urged that Congress act to improve protection against prolonged or severe illness.

PENDING PROPOSALS

Among health proposals pending are the following:

Salk Vaccine Grants—States now are drawing on a \$30 million federal appropriation for the purchase of Salk poliomyelitis vaccine. This authorization expires February 15. The administration will ask for an extension and for another appropriation.

Jenkins-Keogh—This bill, authorizing deferment of income tax on money paid into a retirement fund, was ordered reported favorably by the House Ways and Means Committee on the final day of last session, after it was combined with other tax amendments.

Cash Payments for Disability—This House-passed bill is pending before the Senate Finance Committee. Chairman Byrd has said that extensive hearings will be held on this proposal (a part of H. R. 7225).

MILITARY DEPENDENTS

A new bill for the medical care of dependents of military and other services was introduced. The measure (H. R. 7994) now includes these major points:

1. Authorizes medical care for dependents of members of the Armed Forces and of Coast Guard, Coast and Geodetic Survey and Public Health Service personnel on active duty.

2. Medical care would include diagnosis, treatment of acute medical and surgical conditions

and contagious diseases, immunization and maternity and infant care.

3. The family would have the choice of care directly from the military medical service, if facilities were available, or protection through insurance. The family selecting the insurance method could obtain care from private sources, or it could still use military facilities. The uninsured family receiving direct care from the military could be charged fees for outpatient care, and would be charged subsistence and possibly other costs while in the hospital, expenses that would be paid by the insurance plan in the case of an insured dependent. Thus the extent of these charges (to be set by the military) would determine whether direct military care or insurance would be the most advantageous financially. Insurance companies or plans would pay rates to be set, by Defense Department for care of insured dependents at military facilities.

4. Service families selecting insurance would pay 30 per cent of the cost of a basic plan for wife and children, but the entire cost of coverage for dependent parents and parents-in-law. However, parents and parents-in-law would be eligible for care in military facilities on the same basis as wives and children. Where hospitalization or other benefits are exhausted under a basic plan, the dependent could be transferred to a military facility, or if that were not feasible the government would pay the additional costs for private care.

5. Unlike the earlier Defense Department version, no provision is made for a "hometown care" plan for dependents. That bill allowed use of civilian facilities for dependents not covered by insurance, with the government paying part of the cost. No equivalent protection is provided under the new bill.

Speech Patterns in Psychologic States Will Be Studied

Through a grant of \$35,000 from the National Institute of Mental Health, a study in "psycholinguistics" will be conducted in the University of Cincinnati Department of Psychiatry headed by Dr. Maurice Levine.

The research project will develop a procedure whereby clues in a patient's speech may be used to help reveal his psychologic state. The project will be under direction of Dr. Louis A. Gottschalk, associate professor of psychiatry, who began studies in this field while at the National Institute of Mental Health center in Bethesda, Md. Dr. Gottschalk has been with the UC since 1953.

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Increase in Annual Dues Proposed . . .

Resolution Recommending \$5 Boost Adopted by The Council and Will Be Presented to House of Delegates in April; Statement Explaining Reasons

MEETING on December 10, 1955, The Council of the Ohio State Medical Association by a unanimous vote adopted a resolution recommending to the House of Delegates that the annual per capita dues be increased. This recommendation will be presented to the House of Delegates for official action at the 1956 Annual Meeting, April 10-12, in Cleveland. The following statement has been prepared by The Council to inform the membership of the necessity for an increase in the annual dues:

THE COUNCIL'S STATEMENT

A careful analysis of the current financial picture of the Ohio State Medical Association convinces us that the Association will need additional funds in order to maintain its present activities and services and to finance those additional activities and services which the Association must be prepared to offer to its members.

Specifically, The Council recommends to the House of Delegates that the per capita annual dues be increased \$5.00, effective January 1, 1957, making the total amount of annual dues, \$25.00.

FOUR BASIC ASSUMPTIONS

The foregoing recommendation is based on the following general assumptions:

(1) All of the present activities and services of the Association are necessary and are beneficial, to members individually, and to the medical profession of Ohio, collectively.

(2) The present constructive and progressive program of the Association should be continued; in addition, the Association should prepare to assume new responsibilities.

(3) The Association can reach maximum effectiveness only if it is adequately financed.

(4) The 8,600 members of the Association want a strong, aggressive, well-manned and well-equipped organization, capable of effectively representing the medical profession on public issues and of providing individual members with personal services in a prompt and efficient manner. In contrast, the members do not want the Association to curtail its activities and services and do not want the Association to remain static—either of which would be unrealistic at a time when strong organized action on the part of the profession is highly essential.

PRESENT FINANCIAL PICTURE

By careful management, the Association lived within its current income during the calendar year 1955—in fact, added a small amount to the reserve funds. **However, the excess of income over disbursements was quite small. The Association would have been required to draw on its reserve fund had it been called upon to meet unusual expenditures or an emergency or had it added new activities.**

We believe that the Association should not adopt a policy of deficit financing. Our reserve

funds should be used solely for emergencies and for capital improvements in our Columbus office (equipment, furniture, etc.) when current income may not be adequate for such purchases. Dipping into reserves for day-by-day activities merely postpones the time of decision—the time when the Association must decide whether to go forward, stand still, or retreat.

After checking into anticipated costs of “doing business” during the calendar year 1956, The Council was convinced that the Association would be unable to present a program of activities and services this year comparable to our 1955 program without a rather substantial increase in expenditures. Believing that the membership

does not want the Association to curtail its program, The Council has drafted a budget for 1956 which is in excess of estimated income for 1956. It may be necessary to borrow from our reserve funds to meet this year's budget. However, if the House of Delegates authorizes an increase in dues starting in 1957, the amount taken from the reserve funds can be restored when the budget for 1957 is drafted. If no increase in dues is voted, steps will be taken at once to curtail our program and expenses.

REASONS FOR INCREASES IN OPERATING COSTS

Now, let's take a detailed look at some of the main reasons for the increases in the costs of operating the Ohio State Medical Association.

It is interesting to note that the membership has increased by 1,100 during the past five years. During the same period, new activities and services have been undertaken.

As membership increases and new activities and services are added, requests for personal services and the need for more field work, committee meetings, etc., increase proportionately. This means an increase in the work load at the Columbus Office.

Increasing governmental activity affecting medicine and public health also has added considerably to the work and responsibilities of the State Association, its Headquarters Staff and various committees. There is no evidence that there will be any let-up in the necessity for future continuous contact with various government departments and legislative bodies. In fact, all evidence points to the need for even more activity by medical organization in that field.

EFFICIENT AND ADEQUATE PERSONNEL REQUIRED

To properly handle these additional responsibilities, we have had to be sure that we have an experienced and competent staff at the Columbus Office. At present we have an excellent staff. To retain competent personnel and to secure well-qualified new employees, when necessary, the Association has had to make adjustments from time to time in salaries—to bring them into line with salaries paid by others for comparable reliable and efficient office personnel.

In 1951, just before the present dues were established, the combined payroll for employees of the Association and *The Journal* was \$58,693. The combined payroll covering our 17 employees in 1955 totalled \$77,967.

Keeping in mind that service is the Association's most important product, The Council has taken this attitude: It takes good personnel to provide good service. Good personnel if it is to be retained, must be adequately compensated. Payroll is our biggest individual expenditure but without doubt, our most important one. We believe that increases which we have made in our

payroll during recent years have paid us substantial dividends.

COSTS OF PUBLISHING JOURNAL SOAR

One of our most important, as well as one of our most costly, activities is the publication of *The Ohio State Medical Journal*.

Costs of publishing *The Journal* are tied in closely with labor costs in the printing industry, which are high. As labor costs have increased, the cost of producing *The Journal* has increased proportionately.

In 1947 the cost of printing *The Journal* was \$27,333. By 1950 this figure had jumped to \$37,125. In 1952 it was \$39,000 and in 1953 \$40,163. Last year printing costs were \$49,268. Printing costs in 1955 were about \$56,000. These figures do not include *The Journal* payroll or miscellaneous expenses charged against *The Journal*.

During 1955, revenues of *The Journal* increased because of the sale of additional advertising space. However, the additional receipts—estimated at about \$5,500—were quickly absorbed by increased printing costs.

Taking into consideration all *Journal* expenses, *The Journal* did not quite break even in 1955. It had to use around \$1,100 from its cash surplus for operating expenses.

The paradox of *The Journal* is that an increase in advertising space means that there must be a proportionate increase in the total number of pages in each issue. More pages mean higher printing costs. Moreover, an increase in membership (circulation) means we must print more copies of each issue, which adds to the printing costs.

INCREASES CERTAIN THIS YEAR

It is exceedingly difficult to keep advertising rates abreast of production costs. Advertising contracts are concluded many times six to nine months in advance of the time new advertising rates become effective. Also, we have to be very careful that we do not price ourselves out of the market by raising advertising rates to a figure which our advertisers, or potential advertisers, would consider exorbitant.

So far as 1956 is concerned, we can be sure that we will have to pay more for printing of *The Journal*. The firm which prints *The Journal* is passing on to us a 5 per cent increase in labor costs and an increase of about 7 per cent in the cost of paper. It is estimated that our 1956 billings from our printer will exceed 1955 billings by at least \$3,500.

EXAMPLES OF OTHER BUDGET INCREASES

Since 1952 when an increase in annual dues from \$15 to \$20—the present amount—was authorized, the costs of carrying on many of the long-time regular activities and services of the Association have increased. At the same time, it

has been necessary to expand the budget to take care of some new functions and services. Here are some typical examples:

Because of increasing costs of travel—hotel, meals and transportation—it has been necessary to set aside more money for most of the Association's committees. The same has been true of the amount budgeted for travel expenses of officers and Councilors.

LEGAL EXPENSES

A few years ago the legal expenses of the Association were almost negligible. Now, legal expenses constitute one of the important items in our annual budget. We have found that an increasing number of questions coming before The Council and our committees for study have legal implications. Some of them involve the drafting or analysis of proposed legislation. Others have to do with matters involving professional ethics, disciplinary actions and interpretations of the Constitution and By-Laws of the State Association and those of local societies. For these reasons we have had to secure the services of competent legal counsel. It seems to us as if our legal expenses may grow rather than diminish.

The cost of carrying on Professional Relations has almost doubled during the past four or five years. This item includes the cost of producing and mailing the OSMAGram, promoting the American Medical Education Foundation campaign, mailings of special pamphlets and miscellaneous literature to members, contributions to various professional societies and organizations, etc. We are spending a little more than \$6,000 annually on this activity at this time.

A steady increase in membership has produced a comparable increase in the amount of money which must be used annually for stationery, postage and supplies needed to maintain proper contact between the Columbus Office and our 8,600 members and handle the mass of correspondence which pours into the Columbus Office daily.

RENT, PRINTING, EQUIPMENT

There has been an increase in the rent charged for our headquarters office space which is well located in the downtown area of Columbus where it is convenient for members and others having business with the Association. We are now paying \$9,075 a year, compared to \$7,300 four years ago.

In the production of pamphlets and other material for distribution to members, to county society committees and to the public, we have been confronted with progressive increases in printing costs.

Each year it becomes necessary for us to replace some of our Columbus Office equipment. In making replacements, we have had to pay current market prices for equipment which prices

are anything but low, as any physician well knows.

Several new committees have been set up during the past two or three years. These include the Committee on Veterans Affairs, Committee on Maternal Health and Committee on Hospital Relations. The budget has had to be expanded to provide funds for their activities.

As pointed out earlier in this statement, The Council believes the Association must prepare to meet new responsibilities. This means new activities and services. Following are some of the improvements which can be made in our Association program and examples of some of the new projects which can be undertaken if the House of Delegates concurs in the recommendation for a \$5.00 a year increase in the per capita annual dues.

MORE FIELD WORK IS NEEDED

Plans should be made for more field work out of our Columbus Office. Direct, on-the-spot assistance by staff men to county medical societies in carrying on locally activities in which the State Association is vitally interested should be provided. More secretarial aid should be supplied to members of The Council in their contacts with societies in their respective districts. Likewise, more direct assistance should be given to members of certain staff committees who are responsible for activities of groups of counties on a Councilor District basis. The present Columbus Office staff is not large enough to take on these new responsibilities. Therefore, we are convinced that a new staff assistant should be employed—a man with training and experience in organization work, if possible. This will enable us to expand our field work and give our county societies the additional help they need and should have.

Our present public relations program is for the most part adequate to meet normal conditions and situations. However, if provided with a reasonable increase in its budget, the Public Relations Department will be able to do a better job in helping county societies with their radio and TV programs, setting up exhibits at local public gatherings, and supplying them with literature for public distribution, and similar direct-aid services.

PROFESSIONAL EDUCATION PROGRAM SUGGESTED

The Association should become more active in the field of professional education. We do not propose that the Association should set up programs to compete or conflict with existing professional education projects. However, we believe the Association should take a greater interest in this area than it has during recent years. It should be in a position to give more assistance to groups and organizations providing postgraduate work for physicians. Closer cooperation with our medical schools on postgraduate training programs should be established. More help should be offered the Councilor Districts in

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1. Rosenberg, S. and Oster, K. A., "Gelatine in the Treatment of Brittle Nails," *Conn. State Med. J.* 19:171-179, March 1955.
2. Tyson, T. L., *J. Invest. Dermat.* 14:323, May 1950.

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setting up district meetings. Reorganization of our Speakers Bureau for county medical society speakers should be undertaken. To accomplish these, it will be necessary to provide the Committee on Education with more funds and, perhaps, add to the clerical personnel of the Columbus Office.

MORE ACTIVITY IN HEALTH EDUCATION DESIRABLE

During the past several years we have made our school health program one of our outstanding projects. However, we have just started to scratch the surface. Also, we have not been active enough in the field of health education generally. Therefore, we should step up our interest and activity in health education. Field work with the county medical societies is needed. Funds are needed to provide individual physicians, medical societies and other groups interested in health education with printed material and aids in the form of films, radio and TV script, exhibits, posters, etc.

Other new activities which could be added to the over-all Association program could be mentioned. However, these will illustrate some of the major projects which can be started or expanded if the annual dues are increased.

DUES IN MOST OTHER STATES LARGER

It may interest the physicians of Ohio to know that the present per capita dues of the Ohio State Medical Association are exceedingly low, in comparison to the dues of other state medical societies. Even with a nominal increase of \$5.00, as proposed, the annual dues would be less than the dues of a majority of the state societies. The following breakdown on state society dues, as of September 1, 1955, was secured from the American Medical Association. It shows that all of the state societies but the Ohio State Medical Association and two other societies had annual dues exceeding \$20.00:

Societies charging \$20: Ohio, Alabama, South Carolina. (3)

Societies charging \$25: Arkansas, Delaware, Georgia, Missouri, New York (\$2 special assessment), Tennessee, Virginia, West Virginia, Wyoming. (9)

Societies charging \$28: Connecticut. (1)

Societies charging \$30: Indiana, Maryland (\$10 special assessment), New Jersey, Pennsylvania. (4)

Societies charging \$35: Kentucky, Louisiana, Maine, Massachusetts, Mississippi, Nebraska, Vermont, Washington. (8)

Societies charging \$40: California, Florida, Illinois, Kansas, Minnesota (special assessment \$10), New Hampshire, North Carolina, Oregon. (8)

Societies charging \$42: Oklahoma (special assessment \$35). (1)

Societies charging \$45: Michigan. (1)

Societies charging \$50: Colorado, Iowa (special assessments \$35), Montana, Rhode Island, Texas, Utah. (6)

Societies charging \$55: New Mexico. (1)

Societies charging \$60: Arizona, Wisconsin. (2)

Societies charging \$68: Idaho. (1)

Societies charging \$75: Nevada, North Dakota, South Dakota. (3)

IMPORTANT DECISION SHOULD BE MADE NOW

To summarize: The Association must make an important decision. It can decide to increase the annual dues from \$20 to \$25 and by doing so enable the Association to not only continue with its present forward-looking program but add new services and activities, or it can decide to keep the annual dues at the present figure and by doing so make it necessary for The Council to not only curtail the present program but give up any thought of expanding it.

This Association has the reputation of being one of the outstanding state medical societies of the country. We believe that the members want to keep it in that category. Therefore, we believe that the membership as a whole will concur if the House of Delegates casts a favorable vote on the proposed \$5.00 increase in the annual membership dues—a very reasonable increase but one which is vitally needed to keep our organized efforts at the peak of efficiency.

Resuscitation Courses at Western Reserve

In answer to numerous requests for instruction in the principles of cardiac resuscitation developed by Dr. Claude S. Beck and his associates, the Cleveland Area Heart Society is again offering a practical training course in this procedure. The program is presented two days each month in Dr. Beck's laboratory in Cleveland and combines lectures and laboratory drill. Dr. Beck is director of the course and Dr. Robert M. Hosler, associate director.

Coming dates for the two-day course are February 17-18; March 23-24; April 20-21; May 18-19; and June 22-23. Additional courses will be held in the Fall. Additional information may be obtained from The Cleveland Area Heart Society, 2073 East 9th St., Room 518, Cleveland 15, Ohio.

Trends in Social Security

According to Fred D. Lindsey of the Economic Research Department, Chamber of Commerce of the United States, during September, 1955, one person was drawing unemployment compensation for every 76 persons employed. One person was receiving old age and disability benefits for every 7 persons employed. One person was receiving survivors' benefits for every 18 persons employed. One person was receiving public assistance (old age pensions, aid to the blind, etc.) for every 13 persons employed.

Physician-Hospital Relations . . .

Joint Statement of Basic Principles for Guidance of Ohio Physicians and Ohio Hospitals Adopted by State Medical and State Hospital Societies

DURING the past year several conferences have been held between the Committee on Hospital Relations of the Ohio State Medical Association and the Committee on Professional Relations of the Ohio Hospital Association. Many questions of mutual interest were discussed. Many problems affecting both groups were studied and attempts made to find the answers for them.

One of the major pieces of work done by the two committees was the formation of a joint statement of basic principles to guide physicians and hospitals in their relations.

OFFICIALLY ENDORSED

The statement has been officially endorsed by The Council of the Ohio State Medical Association and the Board of Trustees of the Ohio Hospital Association. In the near future each organization will transmit copies to their local units, urging that the recommendations made in the statement be put into effect in all communities.

Members of the OSMA committee are: George A. Woodhouse, M.D., Pleasant Hill, chairman; Paul F. Orr, M.D., Perrysburg; Robert S. Martin, M.D., Zanesville; Fred W. Dixon, M.D., Cleveland; and Philip B. Hardyman, M.D., Columbus.

Personnel of the hospital association committee is: F. C. Sutton, M.D., Dayton, chairman; R. B. Crawford, M.D., Lakewood; John C. Gettman, Fremont; Edgar O. Mansfield, Columbus; Henry N. Hooper, Cincinnati; and Jay W. Collins, Euclid.

Following is the complete text of the joint statement:

Complete Text of Joint Statement

THIS statement pertaining to relations between physicians and hospitals has the official endorsement of The Council of the Ohio State Medical Association and the Board of Trustees of the Ohio Hospital Association.

It was compiled jointly by the Committee on Hospital Relations of the Ohio State Medical Association and the Committee on Professional Relations of the Ohio Hospital Association after lengthy conferences on questions of mutual interest.

The purpose of the statement is to present certain principles and recommendations which can be used by members of the medical profession and representatives of hospitals in all communities of Ohio as guides for local conferences and to serve as the basis for improved cooperation and understanding.

Much of this statement is based on a report, "Relation of Physicians and Hospitals," adopted in 1953 by the official bodies of the American Medical Association and the American Hospital Association. That report had been prepared by committees of the two national organizations following prolonged conferences.

The joint report of the AMA and the AHA emphasized that "some mechanism must be set up that will bring into frequent and close contact the partners in the hospital endeavor, the administrator, the governing board and the professional staff."

Moreover, it stated that: "It is also necessary that the relationship between physicians and hospitals be clearly defined."

Need for Local Committees Urgent

In their joint pronouncement, the American Medical Association and the American Hospital Association stated that means should be provided at national, state and local levels for review of problems and for conferences on questions of mutual concern to physicians and hospitals. In other words, means must be provided to translate words into action.

Steps to accomplish this have been taken at the national and state levels, i. e., the AMA-AHA joint conferences and the meetings between the committees of the Ohio State Medical Association and the Ohio Hospital Association. There has been little action at the community level.

Therefore, we strongly recommend that in each county in Ohio the county medical society name a committee on hospital relations and that the hospital, or hospitals, in each county name a committee on professional relations. These committees should meet from time to time to discuss questions of mutual interest.

One of their functions would be to initiate a program for carrying out the principles and recommendations enumerated in this report. Another would be to offer suggestions as to how specific problems pertaining to hospital-physician relationships in certain hospitals might be solved.

Liaison with State Committees Important

Moreover, it is recommended that these local committees seek from time to time the advice and guidance of the committees of the Ohio State Medical Association and the Ohio Hospital Association. The state committees will endeavor to provide them with information and with suggestions, based on experience and knowledge of how particular questions have been met in various localities.

Local problems should, if possible, be solved locally. Questions brought to the state commit-

tees should be for the most part those needing interpretation as to the basic principles involved; where the problem actually is more than local in scope and importance; or where the local committees are unable to arrive at an agreement on a problem which may be causing deterioration of the services being provided to the people of the community.

Local Educational Programs Recommended

Finally, we would like to emphasize that we believe there is a real need for an educational program among physicians and hospital officials on the principles and recommendations contained in this statement. Too many times, complete knowledge and understanding on the part of physicians or on the part of hospital officials, or both, are missing. The net result therefore is misunderstanding, problems and an unsatisfactory relationship.

The local committees which have been suggested can do a real educational job if they so desire. The state committees will be requested to assist them in every possible way.

Prompt Local Action and Initiative Emphasized

It is the conviction of The Council of the Ohio State Medical Association and the Board of Trustees of the Ohio Hospital Association that since the physician and the hospital are interdependent, it is incumbent on both to assume the responsibilities set forth in this statement.

Action will not take place automatically. Local programs to carry out the aims and objectives of this joint statement will have to be initiated through the joint planning of county medical society officers, hospital executives and hospital governing boards.

It is hoped that such action will take place promptly in all parts of the state for this reason: The primary purpose of both physicians and hospitals is to serve the best interest of patients. This purpose cannot be achieved unless physicians and hospitals in every community do everything possible to bring about efficiency, coordination, cooperation and understanding in their own relationship.

Some Basic Principles and Recommendations

Following are the basic principles set forth in the AMA-AHA report and which are recommended to Ohio physicians and the officials of Ohio hospitals as a basis for conference and action:

"1. The general purpose of hospitals and physicians is to aid each other in the delivery of the best possible medical care to patients. To attain such a purpose requires full cooperation among medical staffs, governing boards and administrative heads of hospitals. One important method of attaining this objective is that duly designated

representatives of the medical staff shall have free and direct access to the governing board with due consideration to the position of the administrator as chief executive officer of the hospital. The various methods by which the medical staff may have access to the hospital governing board follow. These methods are not listed in the order of their desirability, and there may be other acceptable liaison plans developed depending on local conditions.

"(A) The executive committee of the medical staff and a committee of the governing board with the hospital administrator can serve as a joint committee.

"(B) Representatives of the medical staff can serve as members of the medical staff committee of the governing board with the hospital administrator.

"(C) Representatives elected by the medical staff can attend meetings of the hospital governing board.

"(D) Members of the medical staff can be members of the hospital governing board.

"2. The professional evaluation of chiefs of service and members of the medical staff should be the responsibility of the medical profession. The method of selection of these individuals must be subject to local arrangement and local conditions. In any such arrangement, however, the principle of the freedom of the staff to make recommendations, subject to the approval of the hospital governing board, should be recognized.

"3. The medical profession and the hospitals recognize that certain special services, such as, anesthesiology, pathology, radiology, and physical medicine are integral parts of the practice of medicine and of the services necessary for hospital patients. Physicians in these fields should have the professional status of other members of the medical staff. Chiefs in these specialties must assume also the administrative responsibilities and relationships customarily associated with such positions.

"4. The right of an individual to develop the terms of his services on the basis of local conditions and needs is recognized, but such contractual arrangements should in all cases ensure (a) the policy of professional incentive for the physician, and (b) progressive development of the hospital departments involved, in order that increasingly improved services to patients may be rendered. Moreover, a physician shall not dispose of his professional attainments or services to any hospital, lay body, organization, group, or individual, by whatever name called, or however organized, under terms or conditions which permit exploitation of the patient, the hospital, or the physician.

"5. The chief of a hospital department may have access to financial information regarding his department."

The chances are that in communities where these principles and recommendations are being followed, few, if any, problems or misunderstand-

ings between physicians and hospitals have arisen. If they are put to use in a community, there is reason to believe that existing problems and misunderstandings can be eliminated.

What Are the Problems?

What Causes Them?

What are some of the problems and misunderstandings which have arisen?

What causes them?

Why has it been necessary to draft and distribute a set of principles to define the relationship between physicians and hospitals?

Why are frequent and close contacts between the members of the hospital team even more important today than in the past?

The answers to these, and similar questions, are found in the AMA-AHA report which has been referred to.

The following excerpts from that report should be given studious consideration. They reveal the need for application of the principles and recommendations already enumerated.

"Physicians and hospitals are both concerned with rendering medical care. Their first consideration is their desire to promote the welfare of the patient and the community which they serve. Physicians are the individuals who provide medical care—whether it be in the home, the office, or the hospital. With the ever-increasing complexity of modern medical care, however, the role of the hospital in providing an organization and an environment in which the physician may care for patients is assuming increasing importance.

"Problems associated with the evaluation of services by hospitals and by physicians are different. It is possible to develop minimum standards in a hospital by which the adequacy, type, and quality of hospital service may be measured and compared and the cost per unit of service determined. It is much more difficult to evaluate the services of a physician. Specialty boards have done much to improve the quality of service. Although a specialty board may find that an individual has had good training and that he is capable of carrying out certain procedures, it cannot know what is in his heart and soul, his sense of obligation, or degree of devotion to his duty.

"With the increase in size and complexity, care rendered in hospitals tends to become less personal. In an effort to overcome this, hospitals have striven to indoctrinate all associated with them in the desirability of developing a more individual touch. Medicine, on the other hand, by its very nature, is more personal. It is both a healing art and a science. These two cannot be divorced without grave injury to medicine and to the quality of care received by patients both within and without the hospital.

"With the rapid advance of the science of medicine in the past fifty years, the importance

of the art has been lost sight of by many. The tendency to put faith in the physical attributes of medicine—building, equipment, and technicians—has developed to an increasing degree a mechanistic rather than an intellectual and spiritual approach to medicine and its problems. One evidence of this has been an over-use of and over-dependence on technical procedures in hospitals at the penalty of increased operating costs and possible deterioration in the quality of performance of these technical procedures. This fault does not lie alone at the door of hospitals, since physicians are responsible for the number and type of procedures ordered. It is, however, the result of our present operating procedures and illustrates the failure to integrate adequately the administrative and professional aspects of the hospitals.

"On the other hand, the idea that a hospital should be merely a physician's workshop and supply the facilities and tools to allow him to work unhampered by restrictions is untenable. These tools are too numerous, too unwieldy, and too expensive. Their use needs the coordinated efforts of many persons—nurses, dietitians, technicians of all kinds—as well as those of a physician or physicians. Their proper use still requires the fine discrimination in their selection and application that only a physician can supply.

The Administrator's Duties and Responsibilities

"The administrator, under the direction of a governing board, has the primary responsibility of running a good hospital in which good medical care is provided. He is concerned with costs, personnel, housekeeping, maintenance, and expansion of facilities, as well as with the medical care provided in the institution. It is his responsibility to coordinate into a smooth-running whole the multiple activities of his institution. He looks to the board on the one hand and to the professional staff on the other. Because of the nature of his position and his responsibilities, he looks more directly to the board. His worth, however, must be evaluated finally on the basis of how well he maintains a good hospital within available resources.

The Governing Board of the Hospital

"The governing boards of hospitals are usually made up of men and women of demonstrated ability, occupying positions of prominence, who have evinced interest in community welfare. These persons add strength to the hospitals by their names, general knowledge of affairs, money-raising power, and prestige. They are not necessarily particularly informed as to the many intricate problems involved in the production of good medical care. While there are many who go deeply into the problem of hospital finances and management, few of them ever have the opportunity to make themselves familiar with the problems of medicine. The very nature of their assignment continues this segregation of thought. The board has frequent and often

intimate contacts with the administrator and little or none with the professional staff or its representatives. If they have opinions on medical matters, they are likely to be gained from their personal medical adviser or by casual contacts at social gatherings or on the golf course. It follows, therefore, through no fault of his own, that the administrator may have undue influence with the board in professional matters as well as those that properly come within his province.

Misunderstandings and Why They Occur

"Misunderstandings between hospital management and the medical profession arise from fears concerning each other. Some of these are reasonable and some are unreasonable. Some arise from conflicts of personality in particular institutions. These differences have been aggravated by certain general trends and by proposals coming from within and without the ranks of those providing medical care. A physician desires to maintain and strengthen the art of medicine as well as promote the greatest possible advance in the science of medicine. He sees medicine more and more mechanized and coming more and more under the direction of administrators and boards in hospitals.

"The administrator and the board are concerned not only with the over-all quality and quantity of service rendered by hospitals but also with the financial integrity of their institution. Certain of the factors involved in the production of good medical service come directly and properly under their control. They may be disturbed, however, by dissension in the professional staff, by clique or favoritism, or by failure of the staff to maintain a high quality of professional service. Hence, they may be tempted to interfere with professional control or professional practice. It should be noted that in the past professional standards have been raised substantially through the influence of professional groups and by the action of special committees of the professional staffs of individual hospitals. It would seem unnecessary to state that in a learned and highly technical profession the true qualifications of a member can only be judged by other members of the same profession. The administrator and the board are also troubled at times by multiple and unreasonable demands made on them by the professional staff. This often arises from lack of understanding on the part of the staff members of the total responsibility of the administrator and the total load on the resources of the hospital.

"It is a basic principle that hospital governing boards and administrators should not attempt to tell physicians how to practice medicine but rather must see that the hospital medical staff organizes to provide a framework for staff self-government which will maintain and improve the quality of medical care in the hospital.

Obligations of the Medical Staff

"Physicians, on their part, must understand that the hospital governing board is legally and

morally responsible for the entire operation of the hospital. The medical staff is responsible to the governing board for proper medical care in the hospital.

"The medical profession has provided leadership in improving the quality of care in hospitals. Such efforts, however, do not always receive the support of every member of the hospital medical staff. The authority of the hospital governing board and administrator may be used to enforce rules not complied with by individual members of the staff, although the rules have been developed and approved by vote of the organized medical staff. This authority of the hospital governing board and administrator, when in proper focus, has been an important force in improving the quality of care in the hospitals of this country.

"Lack of understanding and appreciation of these important relationships has caused much criticism and irritation between the members of the hospital governing board, the medical staff and the administrator.

Question of the "Full-Time" Men

"A continued increase in the utilization by hospitals of full-time professional men has disturbed many physicians. In the early days of radiology and pathology, this did not seem a threat to the profession. With the great increase in these services and the advent of anesthesiology, physical medicine, cardiology, and other specialties, this threat and the possibility of friction has increased. The practice in certain hospitals of engaging full-time obstetricians, surgeons, and other specialists has stirred this alarm further. The trend toward a situation, however, where hospitals with a complete full-time staff are engaged in the practice of medicine for a fee, is a matter of concern to many physicians. The profession justly feels that it may lose its independence and become merely a group of high-grade technicians, however respected or highly paid. There are many who believe that a group of physicians working full time, under a lay board, will not produce the best of medical care. There are, however, those in the profession who support the principle of "full time" as a means of providing good medical care in a hospital.

Division of Responsibility Between Staff and Board

"Recognizing the intimate relationship and mutual problems, it follows, then, that there must be a clear and well-defined division of responsibility between the professional staff and the governing board of the hospital. Since they are mutually dependent on each other in providing good care in the hospital, they should be mutually assured by methods of organization that neither can encroach on the proper domain of the other. If all board members, administrators, and physicians were saints, possessed of infallible judgment, perfect in their training and beyond reproach in their actions, there would be

no problem. Since these assumptions are not true, it is necessary to adjust their relationship on a basis that will maintain the prerogatives of each. To accomplish cooperation and understanding, there must be a free flow of information and ideas between the professional staff, the administrative head, and the governing board. Each must accept the primacy of the other in certain fields and all must recognize their interdependence in accomplishing their primary objective. Physicians must become familiar with problems of hospital administration and financing. If they do, they will be more understanding and cooperative in conserving the hospital resources and less demanding in their own requirements. They will also be a much more effective instrument in gaining for a hospital community support for its proper operation."

Poll Conducted on Eisenhower's Health and Second Term

Of 444 specialists in internal medicine polled recently on the question of whether or not President Eisenhower is physically able to serve a second term, 275 replied, according to *U. S. News and World Report* which sponsored the survey, and three out of five indicated that they believe he is. The vote was 141 "yes" to 93 "no." Others replying made comments but did not answer yes or no. The specific question asked was: Based on what you have read about the nature of the President's illness, and assuming a normal convalescence in the next few months, do you think Mr. Eisenhower can be regarded as physically able to serve a second term?

The magazine said the purpose of the poll was to assemble expert opinion on an important question which is at this time of great interest to many people. It was not intended as medical research or as scientific research, it pointed out.

The Journal of the AMA in commenting on the poll said "it seems that the questions are very definitely slanted politically" and that "consultation without examination is absurd." It urged physicians to ignore the questionnaire, but the editorial apparently reached most of the physicians queried after the questionnaires had been filled out and returned.

The poll also asked the question: Do you think a man who has suffered a heart attack can be regarded as physically able to serve a term as President? The vote on this question was 152 "yes" and 84 "no." Some physicians commented on this question, but did not answer specifically yes or no.

Ohioans Certified

Among Ohio physicians introduced into Fellowship in the American Academy of Obstetrics and Gynecology at the fourth annual clinical meeting of the organization in Chicago were the following: Dr. Robert E. Johnstone, Cincinnati; Dr. Richard M. Wilke, Lorain; and Dr. Wilfred B. Bozeman, Jr., Akron.

Military Service Members

The Journal of the AMA, on January 7, carried the following notice to military service members of the AMA: "Each year a large percentage of membership cards sent to military service members are returned to the Membership Department of the AMA headquarters because the address is incorrect. Beginning in 1956, service membership cards will not be sent to service members until the member has sent a postcard or a letter informing this (AMA) office where the card is to be sent. In this way the member will be sure of receiving his membership card, and it will obviate further correspondence in order to try to find out the proper address of the member."

Advisory Council, Enlarged Nursing Board Appointees Named

Governor Frank J. Lausche on January 3 appointed four new members to bring the Board of Nursing Education and Nurse Registration (formerly the State Nurses' Board) to eight persons, and appointed seven members to the newly created Advisory Council to the Board.

One registered nurse and three practical nurses were named in addition to the four incumbent members of the Board. The Governor named Mrs. Helen C. Steinway, of Cincinnati, a registered nurse who is co-ordinator of the school of practical nursing of the Cincinnati Public Schools. Her term will expire January 1, 1961. Three practical nurse appointees are Mrs. Mildred Smith, Springfield, for term ending January 1, 1961; Mrs. Nellie Nixon, Dayton, for a term ending January 1, 1960; and Mrs. Ethel Gesue, Warren, for a term ending January 1, 1959.

Incumbent members are Marjorie Sanderson, R. N., Dayton; Ethel Leazenbee, R. N., Columbus; Sister M. Edith, R. N., Cleveland; and Edna Sharritt, R. N., Toledo.

Members appointed to the new Advisory Council to the Board are Sister Cyril, administrator at Good Samaritan Hospital, Dayton; Wilson Benfer, superintendent of Toledo State Hospital; Dr. Fred W. Phillips, Zanesville; Max Goodson, professor of education philosophy and research, Ohio State University; George F. Quinn, trustee of St. John's Hospital, Cleveland; Sewall Milliken, Columbus, Ohio Public Health Association president, and executive director of the Columbus Metropolitan Health Council; and P. C. Bachtel, West Liberty, assistant supervisor of health, physical education and research in the State Department of Education.

Explanation of the new Nurse Practice Act was given in the December issue of *The Journal*, page 1239.

OASI and Physicians . . .

AMA Journal Contends That Social Security Does Not Offer As Good Benefits for Widows and Children of Physicians As Life Insurance

DEBATE still rages as to whether or not physicians should be covered by the Old Age and Survivors section of the Social Security Act—even among members of the medical profession.

Advocates of compulsory coverage of physicians under the Old-Age and Survivors Insurance section of the Social Security Act contend that self-employed physicians with young children could well afford to pay the entire Social Security tax for the sole purpose of obtaining survivorship benefits under OASI for the widow whose children are under 18 years of age. The maximum amount of these benefits is now \$200 a month. A widow under 65 years of age can receive survivorship (mother's) benefits only if she has in her care a minor child entitled to a child's benefit.

It is also claimed that all other benefits promised under OASI are very desirable; for example, benefits for widows and wives aged 65 and over.

According to an article published in the December 24, 1955, issue of *The Journal of the American Medical Association* "the facts do not support this contention." The article points out that equal or greater benefits for the widow while the children are under age 18 can be purchased from life insurance companies at a lower cost. Following are excerpts from the article which comment on the various phases in considerable detail:

"Under the 1954 amendments to the Social Security Act, the present tax on self-employed persons is 3 per cent of their annual earnings up to \$4,200 a year. Provision is made for an increase to 3.75 per cent during the period 1960-1964, to 4.5 per cent in 1965-1969, to 5.25 per cent in 1970-1974, and to 6 per cent starting in 1975. On earnings of \$4,200 a year, the tax is now scheduled to rise from \$126 to \$252.

"This schedule can be altered, of course, at any future session of Congress. For example, these percentages would be raised by 0.75 per cent under the provisions of H. R. 7225, which passed the House of Representatives last summer by a large majority. It is, therefore, unrealistic to examine this claim about the value of survivorship benefits for the widow with minor children without recognizing that an increase in the tax rate is already scheduled.

"Furthermore, the tax base has risen to \$4,200, and there is a reasonable prospect that a tax base of \$4,800 or possibly \$6,000 may be established in the foreseeable future. For the purpose

of examining this problem, nevertheless, it will be more conclusive to consider \$126 a year as the basis for comparison with life insurance premiums.

COMPARABLE POLICIES

"Few, if any, insurance companies offer policies that precisely match the survivorship benefits under OASI for a widow with minor children. Comparable insurance policies specify a term of years—10, 15, or 20—rather than protection until the youngest child attains 18 years of age. The 'family income' feature comes close to matching these particular OASI benefits, but the premium paying period, unlike the OASI bite, ends with the term of protection.

"For example, a young physician aged 25, by paying an extra annual premium of approximately \$65, can obtain a 'family income' clause—at the time of purchase or later on if he is still insurable—in his \$20,000 ordinary life insurance policy that would pay his family \$200 a month during the interval between his death and the 20th anniversary of the issue of the policy, at which time the children would be 20 years older and the extra premium would cease. If the father died seven years after the issuance of the policy, the family would receive \$200 a month under the 'family income' clause for the next 13 years, when the \$20,000 basic life insurance policy would be payable.

"Thus the face amount of the ordinary life insurance policy is not diminished by the payment of monthly benefits of \$200 a month. If the father survived the 20 year period, the 'family income' clause and its extra premium would terminate.

"For a physician 30 years of age, the premium for a 'family income' clause for \$200 a month would be about \$85 a year; for a physician 35, about \$115 a year; and for a physician 40, about \$166 a year. For this latter comparison, protection for 20 years after the issue of the policy is offered over too long a period for most physicians 40 years of age, because few fathers are over 40 when the last child is born.

"A more realistic counterpart to the survivorship benefits for a widow with minor children under OASI until the youngest child attains age 18 might be a 10 year 'family income' clause for a physician 40 years of age, which would require an annual premium of approximately \$60; the extra annual premium for a 10 year 'family income' clause at age 45 would be only \$83. Almost all self-employed physicians with young children—many employed physicians are

now paying OASI taxes—can purchase the counterpart to OASI survivorship benefits to cover their wives in the event they should become widows and until the youngest child would attain 18 years of age for less than \$126 a year.

NOT ALWAYS MAXIMUM

“The contention that \$126 is a bargain price for the claimed OASI benefits is further weakened by the fact that less than \$200 a month would be payable under the 1954 amendments to the Social Security Act if and when the widow had only one child under 18. The primary insurance benefit for the husband, which is the basis for computing the survivorship benefit for the widow and minor children, would be \$108.50 a month; the survivorship benefit for one minor child would be three-fourths of this amount, \$81.40 a month, and a similar amount for the widow totals \$162.80 a month.

“The fact that many physicians do not leave a widow with minor children is worth noting, although it has no bearing on the argument of young physicians with minor children that this one feature would make OASI a bargain for them. Only by including in the comparison both the widow’s benefit, which would stop should she remarry or return to substantial gainful employment, and the benefits for at least two minor children could a standard of \$200 a month be established for comparing the tax of \$126 a year with the annual premium on a ‘family

income’ clause for \$200 a month added to a \$20,000 ordinary life insurance policy.

“Incidentally, some insurance companies will add a \$200 a month ‘family income’ clause to a \$10,000 life insurance policy. Our concern here is with the extra premium charged for the ‘family income’ clause.

“Over and above these points of superiority in the provision for survivorship benefits for the widow and minor children by the purchase of insurance is the fact that the insurance policy is a contract providing for definite extra premiums for only 10, 15, or 20 years, has a definite scale of benefits, and is enforceable in the courts.

“It is obvious that the original contention about bargain prices under OASI is false even under the assumption that only interested physicians with young children would be covered and taxed; it is not valid for voluntary coverage to say nothing of compulsory coverage, of physicians under OASI.

“Considering the present provisions of the Social Security law, the young physician would fare best by purchasing survivorship benefits for his widow and minor children from a reputable life insurance company under a ‘family income’ clause. Admittedly, survivorship benefits for a widow with minor children are not the only claimed benefits under OASI, but \$126 a year—the initial cost—is an exorbitant price to pay for them alone. Furthermore, a rise to \$252 in the annual tax by 1975 is already scheduled.”

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"Disability Freeze"

Complete Medical Reports Are Important Under This New Provision of The Social Security Act; State Agency Urges Physician Cooperation

PERSONNEL of the Bureau of Vocational Rehabilitation are urging the cooperation of Ohio physicians in the matter of the "Disability Freeze," in which a medical examination form often plays an important role. The so-called "Disability Freeze" is a provision in the law under which a worker may maintain his wage bracket rights under Social Security during a period when total disability prevents him from working.

The following explanation of the new provision and request for cooperation of doctors was prepared by James L. Wallace, supervisor of the Disability Freeze Section of the Ohio Bureau of Vocational Rehabilitation, and Dr. Beryl M. Oser, consulting physician to the Section:

* * *

In view of the large number of disabled people who are applying for the "disability freeze" under the 1954 amendments to the Social Security Act, we feel it is important for the physicians in the State of Ohio to have a better understanding of the program since they have such an important part in it.

From August 15, 1955, to date, we have received approximately 6,000 applications, and there is no indication that the number will drop any appreciable amount in the near future.

From the large number of medical reports we have already received, it is evident that the physicians have not been adequately informed as to the kind and detail of information needed by the applicant to substantiate his claim of total disability.

We hope that the following will be of some help and that physicians will see fit to discuss this matter during one of the meetings in the near future.

PROVISIONS OF THE LAW

On July 1, 1955, the "disability freeze" provisions of the 1954 amendments to the Social Security Act became effective. Disabled workers may now have their Old-Age and Survivors Insurance rights maintained ("frozen") during the period that total disability prevents them from working. In effect, they will be given a "waiver of premium," analogous to the disability waiver of premium commonly provided in private life insurance contracts. Eligibility for retirement and survivors benefits that they have earned up to the time they became totally disabled will be preserved, and the amount of their own retirement benefits and the benefits payable to their

survivors will not be sharply reduced by an extended period of total disability.

The evidence on which the applicant's claim is based, is primarily the medical evidence submitted on his behalf by his attending physician.

The applicant upon making application for the "freeze," is given a medical form and told to present it to his physician. The physician is responsible for completing the form and returning it to the Social Security District Office. The medical record is then incorporated with his application and forwarded to the State of Ohio Bureau of Vocational Rehabilitation, OASI "Freeze" Section, Columbus, Ohio, for adjudication.

OBJECTIVE EVIDENCE NEEDED

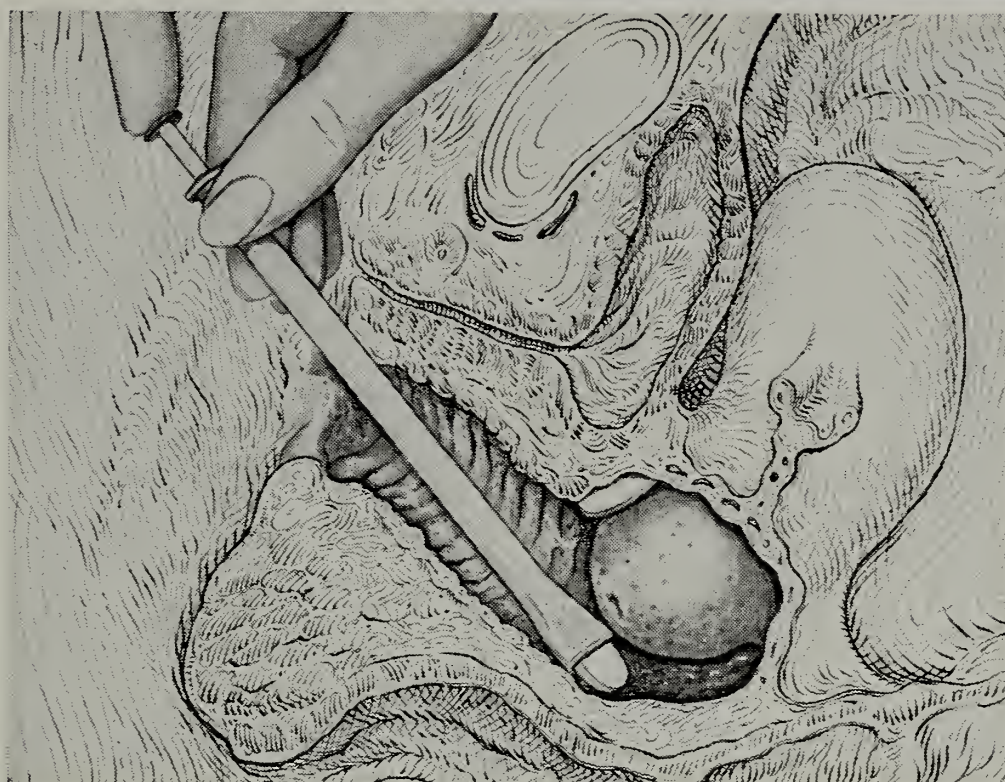
Since the "freeze" provision is not intended to be a "give away" program, absolute objective evidence of the existence of a disability which can be expected to be of a long continued and indefinite duration or that can be expected to result in death, must be supplied. Therefore, the physician, for the benefit of his patient, must submit all the objective evidence of each case, so that the severity of the disability can be established by the consulting physician on the "freeze" program. If all the evidence is submitted on the initial medical form or summary, it will expedite processing the claim in that it will eliminate the necessity for writing the same physician for more objective evidence and clarification.

The statement by a physician that a patient has a particular organic or mental disease and is totally disabled, is of no value without the clinical evidence to support that statement.

There are certain diseases in which laboratory and x-ray data is essential to establish the diagnosis, severity and prognosis. The data must be included in the medical report, i. e. heart disease, diabetes, arthritis, cirrhosis, etc.

Despite the fact that all objective data has been included in the medical report, it will be necessary from time to time for personnel of the Section to write for clarification. We ask that every consideration be given this request, as our case load has exceeded every expectation, and therefore, we only further develop those cases where it is absolutely essential.

Mr. Wallace and Dr. Oser have both offered to cooperate in any way they can with Ohio physicians, and expressed their appreciation for help their office has received. They offered to meet with medical groups and discuss any aspects of the "Freeze."



New Intravaginal Applicator for Improved Treatment of Vaginitis

The restorative treatment of vaginitis with Floraquin is now further improved by a new aid to tablet insertion. Faulty insertion is no longer a failure factor in therapy.

The new Floraquin applicator is designed for simplified insertion of Floraquin tablets by the patient. This plunger device, made of smooth unbreakable plastic, places the Floraquin tablets in the fornices and thus assures coating of the entire vaginal mucosa as the tablets disintegrate. The patient inserts two Floraquin tablets with the applicator in the morning and also two tablets at night, with treatment being continued through at least two menstrual periods. During menstruation it is desirable to increase medication to eight tablets daily to combat the alkalinity of the menstrual flow.

Treatment with Floraquin tablets may be supplemented with insufflation of Floraquin powder by the physician. Frequency of insufflation is determined by the physician, but is of particular importance immediately fol-

lowing the patient's first menstrual period.

Warm acid douches (2 ounces of 5 per cent acetic acid or white vinegar to 2 quarts of warm water) may be taken as often as desired for hygienic purposes.

Floraquin contains Diodoquin® (diiodo-hydroxyquinoline, U.S.P.), the safe and effective protozoacide and fungicide. Lactose, anhydrous dextrose and boric acid are included to help restore the normal acid pH of the vaginal secretions. Such an acid vaginal medium then encourages the growth of normal flora and makes the environment unfavorable for pathogens.

A Floraquin applicator is supplied with each box of 50 (a new package size) Floraquin tablets. G. D. Searle & Co., Research in the Service of Medicine.

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Recap on Polio Program in Ohio . . .

Article Prepared In Attempt To Clear Up Confusion Which Has Arisen in Some Areas of State; Policies and Regulations Reviewed

DESPITE the fact that detailed information regarding the distribution and use of the Salk polio vaccine has been disseminated to all local public health departments and to members of the medical profession, including officers of county medical societies, there has been considerable confusion and misunderstanding in some areas of the state.

The purpose of this article is to review briefly various aspects of the question and attempt to bring members of the Ohio State Medical Association up to date on the program as it is operating in Ohio; also, to take a look at the future vaccine supply and demand.

Since late Summer when the production of the vaccine was resumed following the installation of more rigid manufacturing regulations, *The Journal* has carried a story each month. These have been detailed articles, analyzing official policies and regulations for the information of county medical society officers and all members.

ADVISORY COMMITTEE NAMED

In August, the Governor appointed a special committee to advise the Ohio Department of Health on allocation and distribution of the vaccine on an equitable basis. All vaccine coming into Ohio by Federal regulation is subject to a distribution formula devised by the department. (September *OSMA Journal*, page 920) The Ohio State Medical Association is represented on that advisory committee.

The advisory committee at an early meeting adopted a philosophy aimed at preserving the normal patient-physician relationship. It formulated a distribution system designed to put the bulk of the vaccine into regular commercial pharmaceutical channels. The over-all distribution formula calls for about 80 per cent of the vaccine to be made available to physicians through commercial pharmacy houses and about 20 per cent to be made available to local health and welfare agencies for the inoculation of those dependent on public resources for such service.

MEMO SENT ON OCTOBER 13

In a memorandum issued by Dr. Ralph E. Dwork, director, Ohio Department of Health, on October 13, local public health commissioners were told about the Federal Law providing funds to the states for the purchase of polio vaccine for inoculation of those who do not receive such services from their private physicians.

Dr. Dwork appeared before The Council of the Ohio State Medical Association to discuss the

proposed Ohio program for the handling of the vaccine purchased with Federal funds. The proposal was approved by The Council of the OSMA on September 17. (October *OSMA Journal*, pages 1004-1005.)

FOUR IMPORTANT POINTS

In his communication of October 13 to local health commissioners, Dr. Dwork emphasized the following important factors which should be taken into consideration in setting up a local program for use of the vaccine purchased with Federal funds.

(a) Cooperative agreements should be made with local medical societies in order to solicit their assistance in administering the vaccine purchased with Federal funds.

(b) Parental consent will have to be secured before the actual vaccinations can be given.

(c) Records must be completed for each child for each injection administered. These forms are to be mailed to the Ohio Department of Health following each injection where they will be tabulated for the entire state and the results transmitted to the United States Public Health Service.

(d) Vaccination of those children who do not receive such protection from their family physician can be administered through (1) presently operated public health clinics, (2) especially established clinics for the poliomyelitis vaccine program, (3) providing vaccine directly to private physicians upon request or a combination of either or all three. Whatever method is used, it will be necessary to complete and forward a record for each child following each inoculation.

ALL PHYSICIANS NOTIFIED

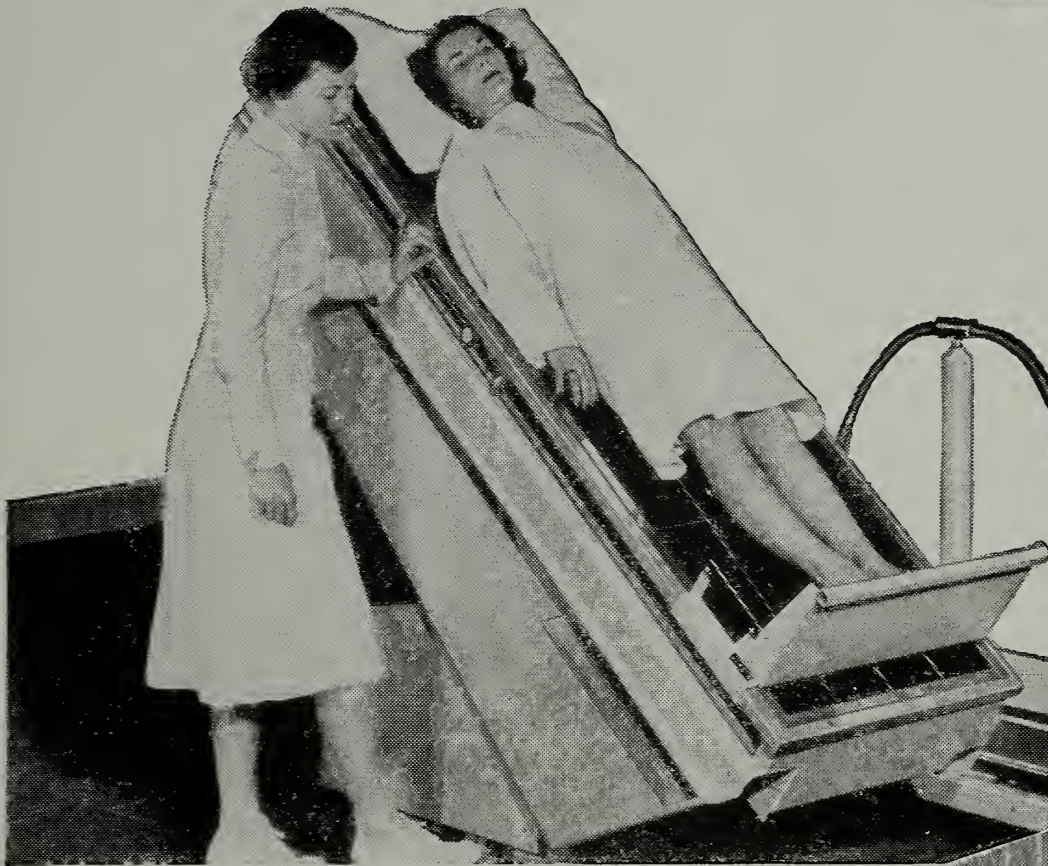
These points were emphasized in the October *OSMA Journal* and in an OSMAgram dated October 10 and sent to all members of the Association.

It is quite obvious that in some areas confusion and conflicts have arisen because (1) the local health commissioner did not confer with the county medical society or (2) the county medical society did not cooperate with the local health commissioner in setting up the local program.

In mid-October the age group of children eligible to receive the vaccine was expanded to include children between the ages of one year through ten years. Also, the new rule included pregnant women. The former age group had been five through nine years.

In a memorandum dated October 21, Dr. Dwork asked local health commissioners for

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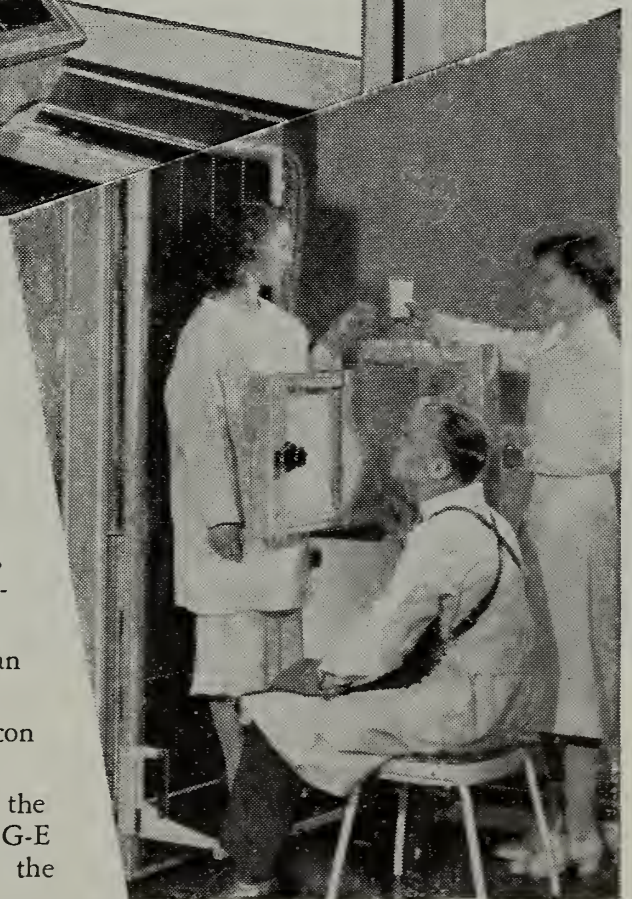
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estimates as to the number of children in the new age group and the number of pregnant women in their respective jurisdictions to help the department in making an equitable distribution of vaccine allotted to Ohio by the Federal Government. In that communication the following pertinent statements were made:

SHORT ON SUPPLY OF VACCINE

"To date, however, Ohio has received only enough vaccine, both for commercial and public agency distribution, for approximately one-half of the children in the five through nine age group. This is excluding those who received their first and second inoculations with the vaccine made available by the National Foundation for Infantile Paralysis. With the expanded age group it therefore becomes apparent that, unless there is an appreciable increase in the production of vaccine and its allocation to Ohio, we face a further deficiency in supplying this material to all those children in the age ranges one through ten and pregnant women. Because of this there will be some further delay in releasing vaccine for distribution to health departments for inoculating those children who do not go to their private physician for such service."

In a reminder memorandum dated December 6 to health departments which did not answer the October 21 memo, Dr. Dwork said:

"As was stated in previous memoranda, vaccine is still in short supply and to date we have only received approximately 20 per cent of that which we feel will be required to protect all of the persons presently considered in the priority group. Whether this supply will increase within the next few weeks remains to be seen. In order, however, that we can plan to distribute what supply we do have as equitably as possible we should appreciate your furnishing us with the information requested in Items 1 through 4 in Memorandum No. 2.

UP TO LOCAL DECISION

In these memoranda, and in public statements, Dr. Dwork made it clear that the Department would exercise no control over distribution on the local level and had advised consultation with the local medical society on this and other aspects of the program. Moreover, he stressed the point that the Department had taken the position that polio vaccine should wherever possible be considered for distribution in the same way as vaccines and biologicals previously available.

Dr. Dwork also has taken the position that while the Federal law provides that no charge may be made for vaccine itself purchased from Federal funds, each physician must decide for himself whether he shall charge, and how much, for administering "free" vaccine.

The following interesting data was secured from the Department for this special article:

In October and November the Department

bought all of two shipments of vaccine allotted to Ohio to get a supply sufficient to make some shipments to public agencies. Some of this material had a short bench life and it was felt advisable to channel such supply into areas where facilities existed for giving a large number of inoculations in a short period. Dr. Dwork stated that this decision was based on the fact that no vaccine is any good sitting on a shelf in a refrigerator and that every effort must be made at all times to get the vaccine into children in the eligible age group.

SOME INTERESTING FIGURES

In December, four shipments of more than 171,000 cc. were all directed by Dr. Dwork into commercial channels for private physician use. One shipment of 52,000 cc. allotted to Ohio early in January has been sent to local pharmacies.

So far 52 health departments have received vaccine. Vaccine is still needed for 116 areas. So far the department has spent \$210,512 for vaccine and \$861,488 remains of the money allotted to Ohio's credit.

For the groups in Ohio who are eligible, approximately 3 million cc. are needed. So far the State has received only 750,000 cc.

Evidence indicates that most physicians are adhering to the prescribed age groups. A small number however are not. The material from government sources was intended for new children in the eligible age groups, not for second or third shots in previously inoculated youngsters.

As the supply becomes more plentiful the age group eligible will be extended. That is not possible yet.

New Members of O. S. M. A.

The following are the names of the new members of The Ohio State Medical Association since December 1, 1955. The list shows the county in which they are affiliated, city in which they are practicing, or temporary address in cases where physicians are taking postgraduate work.

CUYAHOGA COUNTY

Martha J. Bender,
Cleveland
Stanley L. Dobrowski,
Cleveland
Vaun A. Newill, Cleveland
Sam Packer, Cleveland

FRANKLIN COUNTY

Thomas H. Brewer,
Columbus
Leonard J. Burman,
Gahanna
Brooks H. Hurd,
Columbus
Robert J. Izant, Jr.,
Columbus
William Molnar, Columbus
James E. Munger, Lt. j. g.,
Norfolk, Va.
Charles J. Ryan, Columbus
Adelaide E. Sauers,
Columbus
Roy Wm. Starkey,
Columbus

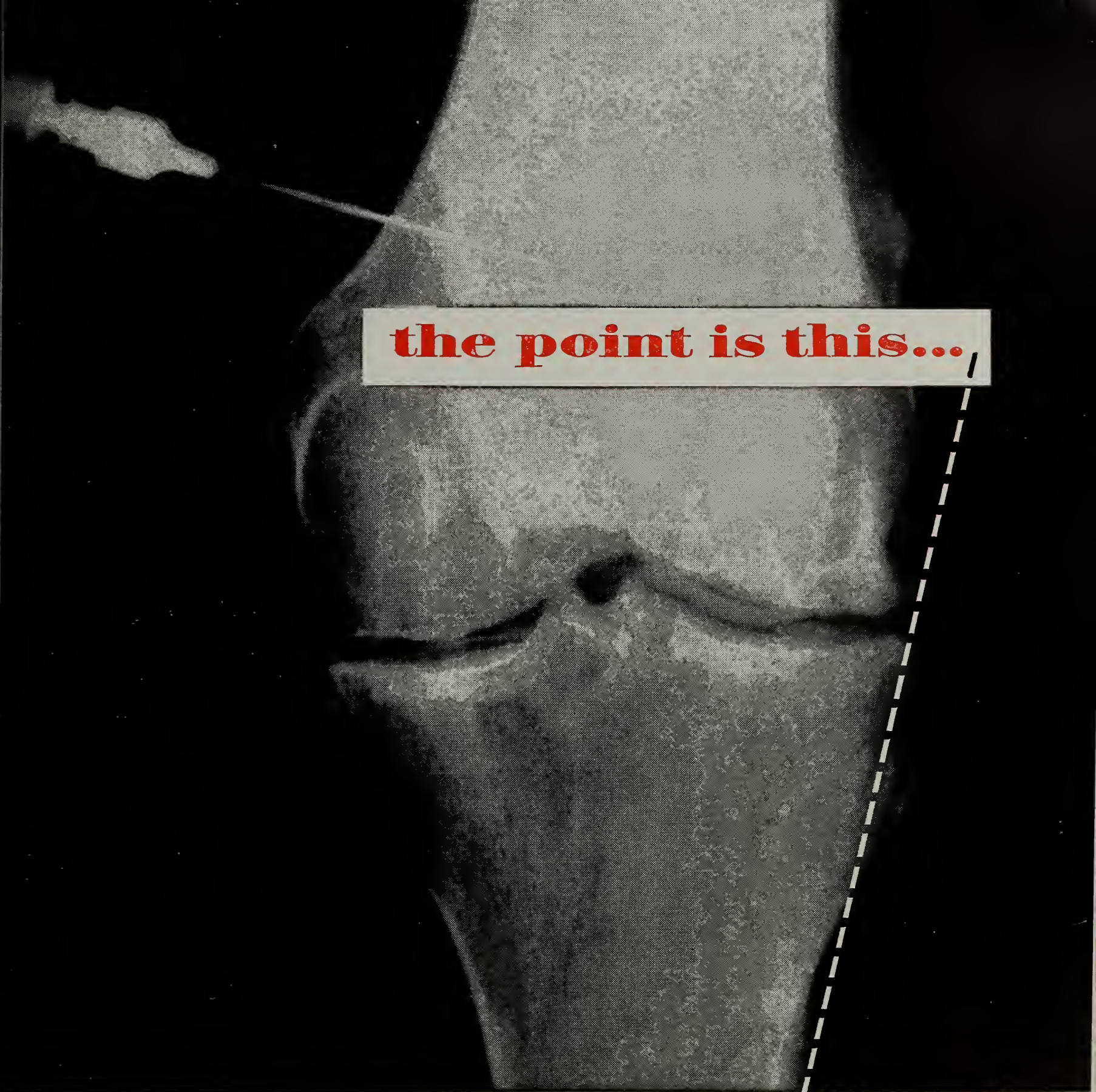
Cyril Taylor, Columbus
Thomas J. Williams,
Columbus
John F. Wiltberger,
Columbus
John B. Ziegler, Columbus

MONTGOMERY COUNTY

Reginald S. Daniel, Dayton
Louis M. Haley, Dayton
James W. Priest, Dayton
Victor M. Shampton,
Dayton
Jack D. Voehringer,
Dayton
Vinton C. Young,
Brookville

SUMMIT COUNTY

Michael C. Bianco, Akron
Francis A. Cleary,
Barberton
Daniel W. Mathias, Akron
Harold M. Schwarz,
Akron



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State Medical Board Examinations . . .

Total of 140 Graduates of Medical Schools Apply for Licenses in the State; List of Questions for M.D.'s at December Examinations Given

THE State Medical Board on December 15, 16 and 17 examined 140 graduates of medical schools who are seeking licenses to practice medicine and surgery in Ohio, according to Dr. H. M. Platter, Secretary of the Board.

Also examinations were given to 33 graduates of osteopathic schools who are seeking licenses to practice osteopathic medicine and surgery in the State. In the limited practice fields examinations were given to the following number of persons: 17 mechanotherapists; 41 chiropractors; 7 chiropodists; 27 masseurs; and 1 cosmetic therapist.

Results of the examinations were scheduled to be announced following a meeting of the Board on January 24, too late to be included in this issue.

Following are the questions given in the examinations for doctors of medicine:

ANATOMY

1. The Diaphragm:
 - (a) What portion of the digestive tract passes thru it?
 - (b) What accompanies this structure thru its opening?
 - (c) What two large vessels penetrate the diaphragm?
 - (d) What is the nerve supply of the diaphragm?
2. Gall Bladder and Bile Passages:
 - (a) Which is the larger, the right or left hepatic ducts?
 - (b) What do they form when they join?
 - (c) What forms the Bile duct?
3. List five significant features of the sternal angle (angle of Louis).
4. The Sciatic Nerve:
 - (a) Of what nerves does it consist?
 - (b) Give its origin (nerve roots), course and distribution.
5. The Trigeminal Nerve, or 5th Cranial Nerve:
 - (a) Origin
 - (b) Name its two component parts.
 - (c) Function: (1) Efferent fibres; (2) Afferent fibres.
6. Describe the auditory pathway from the middle ear to the cerebral cortex.
7. Give the innervation of the heart. (a) Draw a diagram of the heart showing where excitation originates and the paths by which it normally spreads to the auricles and ventricles.
8. Bound Scarpa's triangle (Femoral Trigone), and give its contents.
9. Mediastinum. (a) What are the contents of the middle mediastinum? (b) List five structures found in the superior mediastinum.
10. In amputation of the forearm three inches above the wrist, what arteries will be severed and of what are they branches?

PHYSIOLOGY

1. Briefly describe the digestion of a ham sandwich.
2. Describe what is meant by the term "Oxygen debt."
3. Briefly enumerate the changes taking place in the Acid-Base Equilibrium during pregnancy.
4. Give the function of the semi-circular canals.
5. Briefly describe the function of the pancreas.
6. Describe the endocrine control of menstruation.
7. Give the function of the vagus nerve.
8. (a) What factors determine normal blood pressure? (b) State the significance of a diastolic pressure consistently over 100 mm HG.
9. Distinguish between sensible and insensible perspiration.
10. What factors control the flow of blood to the brain and to the muscles?

BACTERIOLOGY

1. Name and describe the life cycle of a hookworm.
2. In what ways can the clinical diagnosis of histoplasmosis be established?
3. In what ways can the diagnosis of typhoid fever be established?
4. List the common bacterial causes of food poisoning.

5. What is the usual etiologic agent of meningitis with many polymorphonuclear leukocytes and no bacteria on the direct smear of the spinal fluid?

DIAGNOSIS

1. A man aged 55 has had headaches for 5 years. Starting mildly, they have become increasingly severe and are now practically continuous. They are dull in character and diffuse throughout the head, but most severe in the frontal region. He has not previously had headaches of significance. List one disease which could be a probable cause.
2. Give three causes of pyelophlebitis.
3. List the symptoms, the physical signs, and laboratory observations in a patient with infectious mononucleosis.
4. Give the diagnosis of an acute attack of gout.
5. Discuss the control of the medical and the psychogenic factors that delay the healing of a duodenal ulcer.
6. Give the diagnosis of carcinoma of the stomach involving the cardia and the lower esophagus.
7. A male patient, aged 25 years, has painless hematuria as his presenting complaint. List two common diseases that may cause this symptom.
8. Give four psychosomatic factors concerned in the development of chronic ulcerative colitis.
9. A negress, 18 years old, complains of palpitation, easy fatigability, and arthralgia. On physical examination, an apical systolic murmur is heard. Name three diseases with which these manifestations may be associated.
10. List four causes of systemic hypertension and outline the procedures that may be used for differential diagnosis.

CHEMISTRY

1. Discuss the clinical significance of plasma cholesterol concentration in particular reference to liver disease.
2. Discuss plasma proteins as to (a) nature, (b) principal groups or fractions.
3. (a) Give the normal serum albumin concentration (plasma). (b) Give the serum albumin concentration which may be found in the nephrotic syndrome. (c) Advanced cirrhosis.
4. Discuss the distribution of body water as to (a) compartments and (b) cellular activities and factors which condition such activities.
5. What is a buffer? Illustrate.

MATERIA MEDICA AND THERAPEUTICS

1. (a) Define drug incompatibility. (b) Give two examples.
2. Give the nature of action, absorption and excretion of quinidine.
3. Give the mode of action and dosage of two mercurial diuretics.
4. Give the pharmacological action of the bromides.
5. Draw a diagram showing the effects of ACTH and Cortisone upon pituitary and adrenal activity.
6. Give the indications and contraindications to the use of radio active iodine.
7. Name five conditions that modify the effects of poisons.
8. Outline the treatment of osteoporosis.
9. Outline the treatment of bronchiectasis.
10. In the second stage of inhalation anesthesia, give the changes in respiration, eyelid reflexes, eyeball activity and pupils.

PRACTICE

1. Outline the treatment of subacute bacterial endocarditis (endocarditis lenta).
2. Give the immediate management of a massive hematemesis in a female patient thirty years old.
3. In what circumstances should a man with a duodenal ulcer be treated by medical means?
4. Discuss the treatment indicated in poisoning by mercuric chloride taken orally.
5. Outline the treatment of thrombocytopenic purpura.
6. Give the major diagnostic criteria for acute rheumatic fever.
7. Enumerate the causes of hemoptysis.
8. Give the symptoms and complications of diphtheria.
9. Give the symptoms and complications of diabetes mellitus.
10. Give the etiology and signs of paralysis agitans (Parkinson's disease).

PATHOLOGY

1. Classify the gross types of human pulmonary tuberculosis.
2. List the usual gross autopsy findings of subacute bacterial endocarditis.

(Continued on Page 198)

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(Continued from Page 194)

3. List the characteristic gross autopsy findings of typhoid fever.
4. List the results of chronic urethral obstruction.
5. List the gross autopsy findings of tuberous sclerosis.
6. Describe a pseudomucinous ovarian cyst, grossly and microscopically.
7. What is the common destructive non-invasive tumor of the epiphysis of an adult?
8. What are the usual causes of a chronic draining sinus of the skin?
9. What are the gross anatomic findings and chemical clinical findings of islet cell adenoma?
10. What are the causes of Cushing's Syndrome?

SURGERY

1. Enumerate the diagnostic points of differentiation between medical and surgical jaundice in a patient aged 50 years, admitted to the hospital with a history of increasing painless jaundice, anorexia and slight loss of weight over a period of one month.
2. Give the symptoms and diagnostic findings on which a clinical diagnosis of carcinoma of the prostate is made excluding biopsy of prostate.
3. State the indications for tracheotomy.
4. Give the symptoms and diagnostic methods employed in making a diagnosis of carcinoma of the rectum—the lesion lying between 6 and 8 inches above the anal orifice.
5. State the symptoms, diagnosis and treatment of ruptured diverticulitis of sigmoid.
6. Give symptoms, diagnosis and treatment of Pilonidal cyst and sinus.
7. Give symptoms, diagnosis and treatment of Colles fracture.
8. Give differential diagnosis between acute appendicitis and right ureteral stone.
9. Briefly discuss acute suppurative arthritis of knee joint with treatment and differentiate from acute rheumatic fever.
10. Classify burns and give emergency treatment of patient with a burn involving the greater portion of all the soft tissue of the lower extremity.

OBSTETRICS AND GYNECOLOGY

1. Outline what studies should be carried out and what treatment should be given to a young married couple who wish children but have been unsuccessful.
2. What are three possible causes of intrapartum fetal death? Outline the measures that can be taken to circumvent one of these causes of fetal death.
3. Discuss the mechanism by which uterine hemorrhage is controlled in the third stage of labor. What are the factors that may influence this mechanism?
4. An apparently healthy six month pregnant woman begins to have swollen feet, ankles and legs. Discuss cause and management.
5. Describe the clinical characteristics of two common vaginal conditions producing discharge and pruritus vulvae.
6. Discuss the symptoms and physical signs that may be present at the eighth week of a normal pregnancy.
7. What laboratory studies are indicated in the pregnant patient from the initial examination to delivery?
8. What conditions usually indicate that labor should be induced?
9. A woman 30 years of age has a suspicious appearing cervix. (a) How would you handle her? (b) What if you found her pregnant?
10. What anesthetics are used in delivery? What are the advantages of different methods?

SPECIALTIES

1. Discuss the appearance, differential diagnosis, cause and treatment of scabies.
2. Discuss the five most common diseases that cause an abnormal appearance in the naso-pharynx and give treatment.
3. A 26 year old man complains of burning on urination and frequency. How would you handle this case?
4. What laboratory tests are available to make the diagnosis of syphilis? Gonorrhea?
5. True or False?
 - (a) The pupil constricts for distant vision.
 - (b) Heterochromia iridis is an abnormal staining of the iris caused by a drug.
 - (c) An Argyll Robertson pupil does not contract for near vision.
 - (d) Pain and laziness of the cornea suggests acute glaucoma.
 - (e) Mydriatics cause dilatation of the pupil.

PREVENTIVE MEDICINE AND HYGIENE

1. Discuss the responsibility of the physician in the prevention and control of drug addiction.
2. What is the mode of transmission of each of the following diseases: (a) trichinosis, (b) anthrax, (c) leptospiral jaundice, (d) Rocky Mountain spotted fever.

3. Outline procedures to control an outbreak of malaria fever in a community.
4. (a) What is potable water? (b) What does the presence of high ammonia nitrogen in water indicate? (c) What does a high chloride content in water indicate?
5. Name five common milk-borne diseases. (b) How can milk-borne diseases be prevented? (c) What is the minimum bacteria count allowable per cc. in raw milk and in pasteurized milk to be classed "Grade A"?

Do You Know? . . .

Following a lecture at the Pasteur Institute in Paris, France, Dr. Albert B. Sabin, professor of research pediatrics at the University of Cincinnati College of Medicine, was awarded a silver Pasteur Institute medal in recognition of his research.

* * *

Three Ohioans are scheduled to participate on the program of the Mid-South Postgraduate Medical Assembly in Memphis, Tenn., February 14-17. They and the field of their discussions are as follows: Dr. George L. Sackett, Cleveland, x-ray; Dr. Warren E. Wheeler, Columbus, pediatrics; Dr. John C. Ullery, Columbus, obstetrics and gynecology.

* * *

Hart F. Page, Assistant Director of Public Relations, Ohio State Medical Association, is the new Vice-President of the Columbus Chapter, Public Relations Society of America.

* * *

At the recent clinical meeting of the American Academy of Obstetrics and Gynecology, Chicago, Dr. John C. Ullery, chairman, Department of Obstetrics and Gynecology, Ohio State University College of Medicine, was elected assistant secretary, and Dr. A. Clair Siddall, Oberlin, won honorable mention in the Scientific Exhibit for his exhibit on "A New Frontier in Private Practice."

* * *

The First International Symposium on Venereal Diseases and the Treponematoses will be held at the Statler Hotel, Washington, D. C., May 28 - June 1. The symposium will be sponsored by the Public Health Service, U. S. Department of Health, Education and Welfare and the World Health Organization.

* * *

Dr. Louis J. Regan, 63-year-old Los Angeles medicolegal expert, who was a member of the AMA Committee on Medicolegal Problems, died of coronary heart disease.

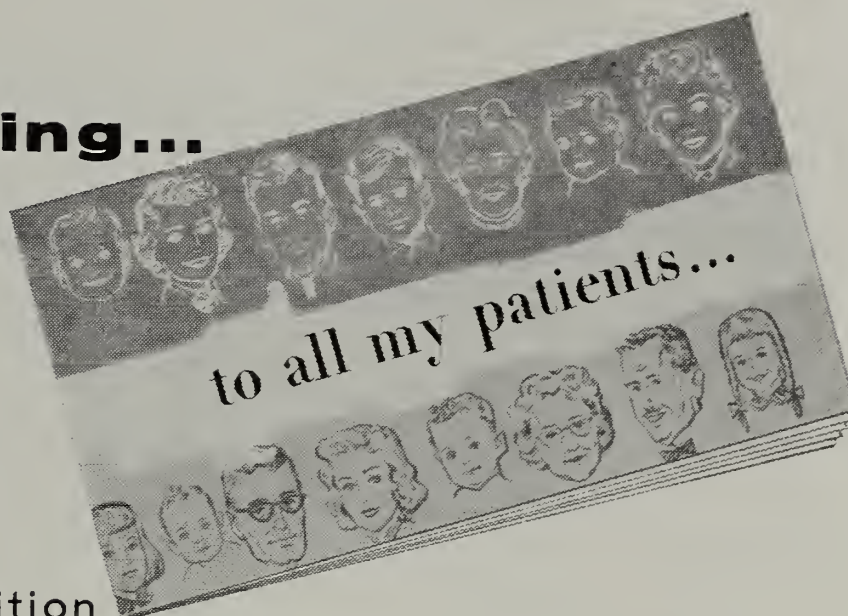
* * *

Fred V. Hein, Ph. D., consultant on health and fitness in the AMA Bureau of Health Education, was honored recently when he was named president-elect of the American School Health Association.

* * *

Arrangements have been completed for building of the \$1,300,000 Forest City Hospital. Construction of the 92-bed hospital will begin early in the year.

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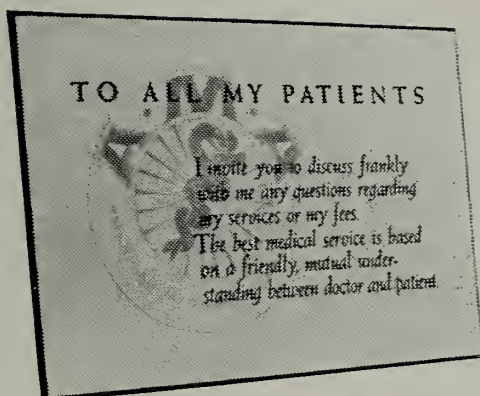
of **PR** aids *sure to make a hit with your patients by providing written answers to many questions about their medical care.*

AMA now offers you its newest publication designed as a PR adjunct to your medical practice. **TO ALL MY PATIENTS** is just one of several public relations pieces recently developed by AMA to help you and your patients achieve that mutual understanding so important to a successful doctor-patient relationship. This attractive 12-page pamphlet—which was mailed to all AMA members—briefly describes the responsibilities of various persons on the medical team . . . discusses medical and hospital fees and health insurance . . . and encourages a friendly discussion of medical services and fees.

TO ALL MY PATIENTS begins: "I appreciate the confidence you have expressed in me by selecting me as your physician. I sincerely hope that I can give you and your family the kind of medical service you desire. . ."

TO ALL MY PATIENTS concludes: "It is difficult for a physician briefly to explain every service necessary in providing good care because each case is different. I sincerely hope this leaflet will give you a better understanding of some of the services you may require. . ."

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Ohio Heart Association Plans Program In Cleveland for April 9

Dr. Geza de Takats, of Chicago, and Dr. Clarence W. Lillehei, of the University of Minnesota, will be the principal speakers at the Annual Meeting of the Ohio State Heart Association to be held Monday afternoon, April 9, at the Hotel Statler in Cleveland, it was announced by Dr. J. Lester Kobacker, Toledo, chairman of the Program Committee.

"Vascular Disease in the Modern Medical World" will be the subject of the panel moderated by Dr. de Takats and assisted by Dr. Alfred W. Humphries and Dr. Keith Sheldon, of Cleveland. Dr. Lillehei will speak on "Direct Vision Inter-cardiac Surgery" as well as present a colored motion picture.

Dr. Kobacker pointed out that this program will be of real interest for both the physician in general practice and the cardiologist.

Running concurrently with the foregoing program will be a Public Health Meeting on "Heart Disease—A Community Responsibility." The Child With Rheumatic Fever and Rheumatic Heart Disease and Community Education and Heart Disease will be the main topics on this program.

Assisting Dr. Kobacker on the Program Committee are: Dr. Bernard Brofman, Cleveland; Dr. J. A. Browning, Warren; Dr. R. W. Kissane, Columbus; and Mrs. Carl Strauss, Cincinnati.

Iowa Hospitals Appeal Recent Decision

The Iowa Hospital Association and 34 member hospitals have decided to appeal all points of the recent district court ruling in the suit brought by hospitals against certain medical specialists.

The appeal was voted by representatives of all Iowa hospitals during a special meeting of the Association's General Assembly December 9 in Des Moines.

On November 28, Judge C. Edwin Moore of Polk County District Court, Des Moines, ruled that Iowa hospitals have been practicing medicine illegally. No distinction was made between non-profit and for-profit institutions.

Judge Moore also ruled that defendant pathologists and radiologists have been violating the Iowa Code prohibiting fee-splitting.

In announcing its decision to appeal, the Iowa Association said hospitals felt Judge Moore's decision of such tremendous national importance that it should not be allowed to stand without appeal.

IHA officials said that possible recourse to the legislature had been mentioned. They said, however, the Association felt it would be proper public procedure to exhaust all judicial remedies before turning to the legislature.

CLINICAL REVIEWS

MAYO CLINIC AND MAYO FOUNDATION

April 9, 10 and 11, 1956

ROCHESTER, MINNESOTA

This 3-day program will be devoted to lectures and discussions on problems of current interest in general medicine and surgery. The presentations will be made by staff members of the Mayo Clinic and the Mayo Foundation for Medical Education and Research.

The number of physicians who can be accommodated is necessarily limited. Those wishing to attend should communicate with Mr. R. C. Roesler, Mayo Clinic, Rochester, Minnesota.

There are no fees of any kind.

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Single-tablet medication combines 3 mg. Veriloid (alkavervir), a potent hypotensive agent noteworthy for its safety,³ with 1 mg. Rauwiloid. High efficacy from lower Veriloid dosage, with greatly reduced side actions to Veriloid. Initial dose, one tablet t.i.d., p.c.

Rauwiloid® + Hexamethonium / *In Severe, Otherwise Intractable Hypertension*

Combines ganglionic blockade action of hexamethonium chloride dihydrate (250 mg. per tablet) with Rauwiloid (1 mg.) in a single tablet for easier, safer, ambulatory management of severe cases. Initial dose, ½ tablet q.i.d.

1. Moyer, J.H., in discussion of Galen, W.P., and Duke, J.E.: Outpatient Treatment of Hypertension with Hexamethonium and Hydralazine, South. M.J. 47:858 (Sept.) 1954.

2. Moyer, J.H.; Dennis, E., and Ford, R.: Drug Therapy (Rauwolfia) of Hypertension. II. A Comparative Study of Different Extracts of Rauwolfia When Each Is Used

Alone (Orally) for Therapy of Ambulatory Patients with Hypertension, A.M.A. Arch. Int. Med. 96:530 (Oct.) 1955.

3. Wilkins, R.W.; Stanton, J.R., and Freis, E.D.: Essential Hypertension. Therapeutic Trial of Veriloid, a New Extract of Veratrum viride, Proc. Soc. Exper. Biol. & Med. 72:302 (Nov.) 1949.

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In Memoriam . . .

Newton S. Banker, M. D., Cleveland; Western Reserve University School of Medicine, 1905; aged 80; died December 29; member of the Ohio State Medical Association and the American Medical Association. Only recently Dr. Banker had been recognized by the Academy of Medicine of Cleveland when he received the 50-Year Pin and Certificate of the Ohio State Medical Association. All of his professional career was served in the Cleveland area.

Von Bergen Barnhiser, M. D., Camden; University of Cincinnati College of Medicine, 1928; aged 54; died December 18; member of the Ohio State Medical Association and former member of the American Medical Association; past-president and former vice-president of the Preble County Medical Society and active on numerous local committees. A native of Preble County, Dr. Barnhiser returned there to practice upon completion of his medical training. During World War II, he served in the Medical Corps with the Air Force where he attained the rank of lieutenant colonel. He was a member of several Masonic bodies. Survivors include his widow, his mother, four brothers and four sisters.

Raymond G. Boehme, M. D., Springfield; University of Cincinnati College of Medicine, 1911; aged 67; died December 12; member of the Ohio State Medical Association and the American Medical Association. Dr. Boehme first moved to Clark County in 1916 and opened a practice in Enon where he remained for two years before moving to Springfield. He was a member of the Methodist Church and the Masonic Lodge. Survivors include his widow, two daughters and three sons.

Emil D. Buhrer, M. D., Urbana; Eclectic Medical College, Cincinnati, 1902; aged 78; died December 17; member of the Ohio State Medical Association through 1946; a former president and vice-president of the Champaign County Medical Society, having served several terms in those offices. Dr. Buhrer began practice in Terre Haute, Champaign County, but early moved to Urbana. He retired from practice in 1940. Survivors include his widow, a daughter and two sisters.

John W. Burrows, M. D., Berea; St. Louis University School of Medicine, 1932; aged 50; died December 14; member of the Ohio State Medical Association and the American Medical Association. Dr. Burrows practiced in Lakeside from 1934 to 1942, when he entered the Army Medical Corps. He began practice in Berea following the war. He was a member of the Catholic Church, the Knights of Columbus and the Holy Name Society. Surviving are his widow, a

daughter, his mother, a sister and three brothers, one of whom is Dr. Ernest J. Burrows, of Cuyahoga Falls.

Harold R. Conn, M. D., San Francisco, Calif.; Jefferson Medical College of Philadelphia, 1912; aged 66; died December 15; former member of the Ohio State Medical Association and the American Medical Association; member of the American Orthopedic Association, the Clinical Orthopedic Society, the American Academy of Orthopedic Surgeons, the American Association of Industrial Physicians and Surgeons, Fellow of the American College of Surgeons and diplomate of the American Board of Orthopedic Association. Dr. Conn conducted a private practice in Akron and was surgeon for the Goodyear Tire & Rubber Company from 1919 until 1940. In that year he began full-time service for the Goodyear Company. He moved to California in 1949. Dr. Conn had an outstanding military record. He served in World War I, and during World War II was a member of the National Research Council's Advisory Committee on Orthopedic Surgery; he also was consultant to the former Fifth Service Command. One of his numerous monographs was "The Battalion Medical Officer." His widow survives.

Harry O. Cooper, M. D., Lockland; Medical College of Ohio, Cincinnati, 1894; aged 86; died December 25; former member of the Ohio State Medical Association. Dr. Cooper had been a practicing physician over a period of 55 years, most of it in the Lockland area where he moved from Reading in 1896. His widow and a son survive.

Forest O. Garver, M. D., DeGraff; Eclectic Medical College, Cincinnati, 1917; aged 64; died December 8; former member of the Ohio State Medical Association; secretary-treasurer of the Logan County Medical Society in 1926-1927. Dr. Garver served all of his professional career in the Logan County area, principally in DeGraff where he maintained an office until 1954. His country home was in Champaign County near DeGraff. Dr. Garver was a member of the Presbyterian Church and the Masonic Lodge. He is survived by his widow and a daughter.

Ziba Lindley Henry, M. D., San Francisco, California; Starling Medical College, Columbus, 1896; aged 82; died October 16; former member of the Ohio State Medical Association; more recently a member of the California Medical Association and the American Medical Association. Dr. Henry practiced in Knox County and at Amesville until 1908 when he entered the U. S. Army. He retired as a Colonel in 1943. He was a member of the Presbyterian Church, sev-

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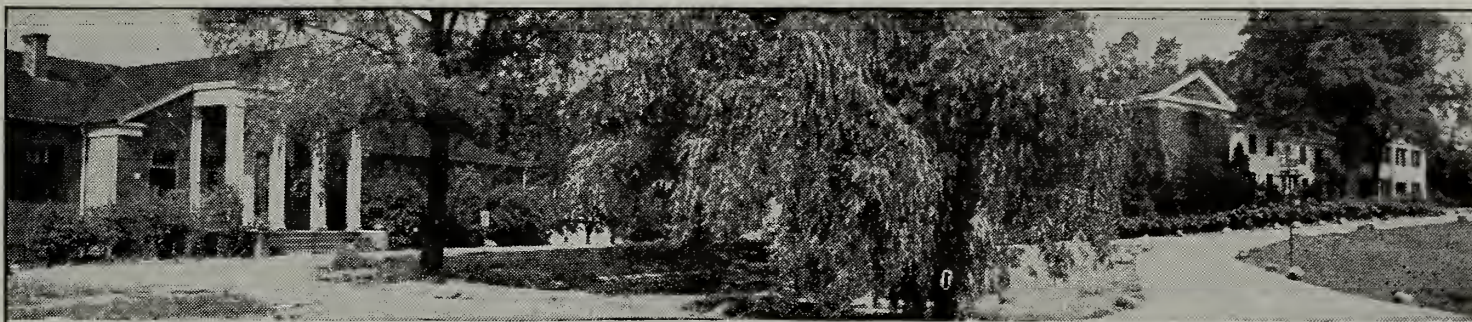
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L. C. ROETTIG, M. D.
Surgeon and Consultant

eral Masonic bodies, the American Legion and the Sons of the American Revolution. Survivors include his widow; four children; a twin brother, Dr. William H. Henry, of Middletown, and another brother.

Henry B. Kistler, M. D., Newcomerstown; Starling Medical College, Columbus, 1902; aged 76; died December 9; member of the Ohio State Medical Association through 1950 when he retired because of illness; past-president and former vice-president of the Tuscarawas County Medical Society. Dr. Kistler practiced at Sunbury until 1918 when he moved to Newcomerstown. He was a member of the Catholic Church. Survivors include his widow, a son, a daughter, a sister and a brother.

Arnold Leeds, M. D., Middletown; Heidelberg University, Germany, 1913; aged 70; died December 14; member of the Ohio State Medical Association and the American Medical Association. Dr. Leeds began practice in Middletown 16 years ago after he came to this country from Germany. He had practiced a total of 45 years. Surviving are his widow, a daughter, and a sister.

George E. Rice, M. D., Chagrin Falls; Ohio State University College of Medicine, 1933; aged 50; died January 6; member of the Ohio State Medical Association and member of the American Medical Association; diplomate of the American Board of Internal Medicine. Dr. Rice began practice in Chagrin Falls after he completed residency training in Cleveland. He is survived by his widow, three sons, a daughter, his mother and two brothers.

Carrie A. Richeson, M. D., Bellefontaine; National Normal University College of Medicine, Lebanon, Ohio, 1892; aged 88; died December 18; member of the Ohio State Medical Association through 1946; secretary of the Logan County Medical Society in 1919. Dr. Richeson was a practicing physician in Bellefontaine from the early 1890's until 1947 when she retired. She was a life member of the Ohio State Suffrage Association and a member of the Order of the Eastern Star and other organizations. A sister and a brother survive.

John Fletcher Robinson, M. D., formerly of Mt. Vernon; Albany Medical College, New York, 1906; aged 72; died November 27 in England; member of the Ohio State Medical Association, 1950-1952. Dr. Robinson was on the staff of the Mount Vernon State Hospital for five years. He and his wife had returned to England in October after having previously been there. Mrs. Robinson died two days after her husband.

Edwin Herbert Season, M. D., Covina, Calif.; Western Reserve University School of Medicine, 1898; aged 83; died December 22; member of the Ohio State Medical Association through 1950. Dr. Season served all of his professional career in Cleveland and in 1949 was presented the 50-

Year Pin and Certificate of the Ohio State Medical Association. He retired and moved to California in 1948. Surviving are his widow; two sons, John A., and Dr. Edwin H. Season, Jr., a dentist; and a step-son, Dr. Herbert W. Salter, of Cleveland.

Victor V. Wick, M. D., Santa Ana, Calif.; Jefferson Medical College, Philadelphia, 1900; aged 78; died December 12. Dr. Wick practiced for many years in Youngstown before he retired and moved to California in 1940. A sister survives.

Ida M. Wilson, M. D., Columbus; Ohio Medical University, Columbus, 1896; died December 19; former member of the Ohio State Medical Association. Dr. Wilson retired in 1949 after practicing for many years in Columbus. She was a member of the Women's Medical Club and the Women's Republican Club.

John Parma Wycislik, M. D., Cleveland; Western Reserve University School of Medicine, 1919; aged 69; died January 1; member of the Ohio State Medical Association and the American Medical Association. Dr. Wycislik practiced in the south-east area of Cleveland for about 35 years. He was one of the group which promoted establishment of Marymount Hospital. A native of Poland, Dr. Wycislik came to this country as a youth. He was active in local Polish organizations and was a member of the Catholic Church. Surviving are his widow, a son, a daughter and a brother.

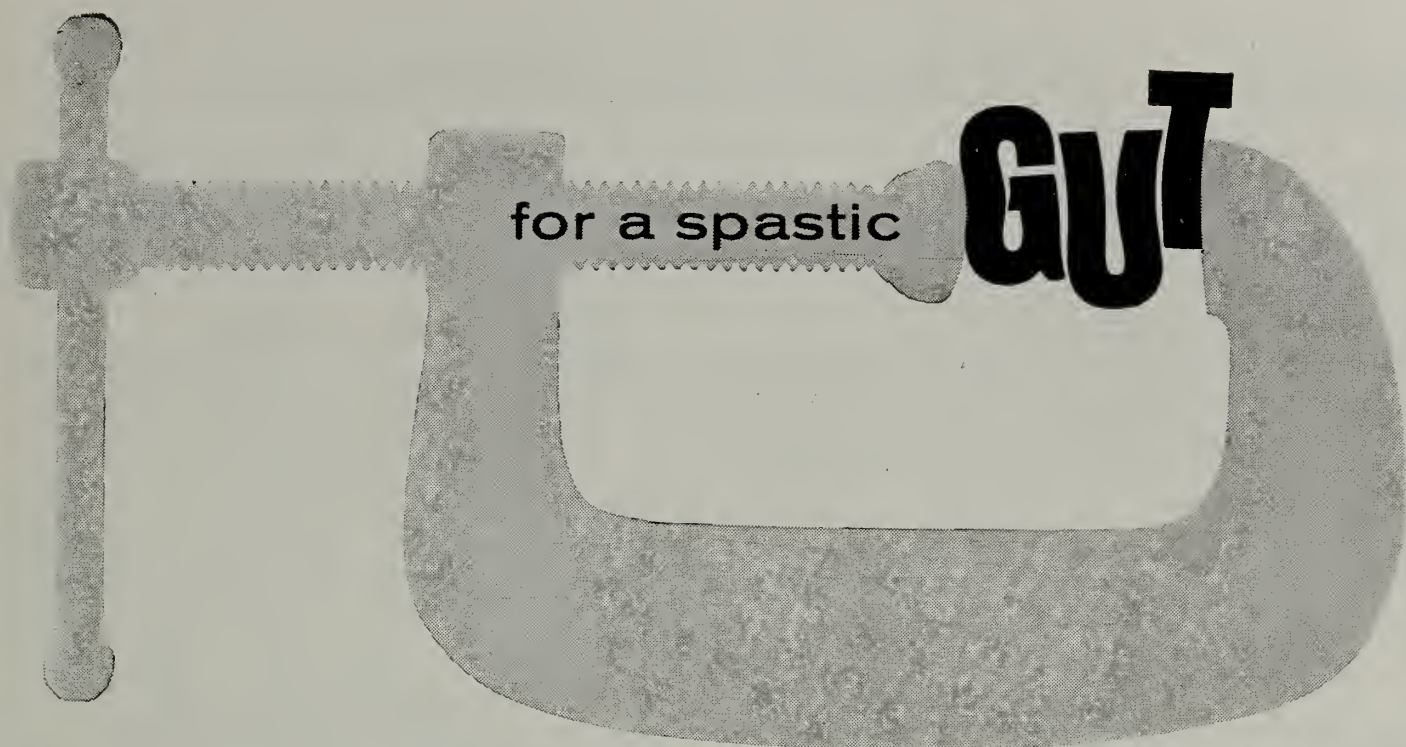
Ob-Gyn Physicians Invited To Dinner Meeting, Cleveland, April 9

Ohio specialists in obstetrics and gynecology planning to attend the Annual Meeting of the Ohio State Medical Association in Cleveland, April 10, 11 and 12, are cordially invited to the regularly scheduled meeting of the Cleveland Society of Obstetrics and Gynecology at the Cleveland University Club, 3813 Euclid Avenue, on Monday evening, April 9. Cocktails will be served at 6:30 P. M. and the dinner will follow. Cost will be \$5.00 per person.

The guest speaker will be Dr. William Kroger, Chicago, who will speak on "Psychosomatic Aspects of Obstetrics and Gynecology." He is an entertaining and interesting speaker; the author of *Psychomatic Gynecology*.

Dr. Kroger will remain in Cleveland for informal talks and conferences on April 10 with physicians who may be interested in the application of hypnosis to obstetrics and gynecology.

Physicians planning to attend the dinner on Monday, April 9, or who wish to meet with Dr. Kroger on Tuesday, April 10, should get in touch with Dr. Eduard Eichner, secretary of the Cleveland society, 10605 Chester Avenue, Cleveland 6, so adequate accommodations can be made for the April 9 dinner and arrangements made for physicians to confer with Dr. Kroger on April 10.



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Activities of County Societies . . .

First District

(COUNCILOR: CHARLES T. ATKINSON, M. D.,
MIDDLETOWN)

HAMILTON

The Academy of Medicine of Cincinnati honored four physicians at the November 15 meeting when they were presented the 50-Year Pin and Certificate of the Ohio State Medical Association. They are:

Dr. Theodore Bange, graduate of the Miami Medical College, has practiced all of his professional career in Cincinnati where he has offices at 2901 Clifton Avenue.

Dr. Emmet Fayen, a practicing physician in Cincinnati and physician for the Union Central Life Insurance Company for 25 years. At one time he was in charge of the Veterans Administration fight against tuberculosis in Ohio, Indiana and Kentucky.

Dr. Lester W. Stacey, who retired three years ago after practicing for many years in the Norwood area.

Dr. E. O. Swartz, a practicing physician and surgeon in Cincinnati for most of his professional career, is past-president of the Academy of Medicine of Cincinnati, past-president of the Ohio State Medical Association and active in many other phases of organization work.

A Symposium on the Newer Antibiotics was the feature of the December 20 meeting of the Academy of Medicine of Cincinnati. Panel discussants for the occasion were: Dr. Harry F. Dowling, professor and head of the Department of Medicine, University of Illinois; Dr. William A. Altemeier, professor and director of the Department of Surgery, University of Cincinnati; and Dr. Morton Hamburger, associate professor of medicine, University of Cincinnati.

The Academy business meeting was held on January 3. The following persons gave reports as indicated:

Dr. Charles A. Sebastian, president of the Academy, introductory remarks and comments on the subject.

Dr. Robert Howard, president of the Physicians' Business Bureau, "Functions and Services of the Physicians' Business Bureau."

Dr. Nicholas J. Giannestras, chairman of the Veterans' Affairs Committee, "Survey on Veterans Administration Facilities."

Dr. John A. Fisher, chairman of the Committee on Public Policy and Legislation, "Social Security and Pending Legislation."

Dr. J. Robert Hudson, chairman of the Public Relations Committee, "Your Public Relations."

Dr. Mervin Steves, chairman of the Committee on Medical Economics, "Survey on Doctors' Time Given Without Remuneration."

Dr. Ralph C. Carothers, chairman of the Hospital Liasion Committee, "Hospital Costs—The Doctor and the Hospital."

Second District

(COUNCILOR: G. A. WOODHOUSE, M. D.,
PLEASANT HILL)

CHAMPAIGN

Dr. V. G. Wolfe was honored at the annual Christmas party of the Champaign County Medical Society at the Urbana Country Club on December 14. During the evening he was presented the 50-Year Pin and Certificate of the Ohio State Medical Association by Dr. George A. Woodhouse, Pleasant Hill, Councilor of the Second District. Dr. Mark Houston read a poem which he wrote in honor of Dr. Wolfe.

DARKE

The regular monthly meeting of the Darke County Medical Society was held at the James Hotel on January 17 with dinner. Speaker for the occasion was Dr. R. L. Taylor, Dayton, who discussed the subject, "Acute Chest Injuries."

GREENE

Dr. Samuel N. Maimon, Dayton, was guest speaker at the January 12 meeting of the Greene County Medical Society at the Greene Memorial Hospital, Xenia. His subject was "Chronic Pancreatitis."

MIAMI

Dr. John J. Cranley, University of Cincinnati College of Medicine, spoke on the subject, "Venous Insufficiency of the Lower Extremity," at the January 13 meeting of the Miami County Medical Society in the Stouder Hospital, Troy.

MONTGOMERY

Rabbi Selwyn D. Ruslander addressed the Montgomery County Medical Society and Auxiliary at the December 3 meeting in the Biltmore Hotel. His subject was "Living Together in Faith."

Third District

(COUNCILOR: JAMES R. JARVIS, M. D., VAN WERT)

CRAWFORD

On December 14 the annual meeting of the Crawford County Medical Society was held at Greenlawn Restaurant. Twenty-one members and 19 wives were present for dinner. Bingo and bridge followed the dinner.

Annual election was held and the officers for 1956 are as follows: Dr. Karl Barth, New Washington, president; Dr. T. D. Sawyer, Crestline, vice-president; Dr. F. E. Moore, New Washington, secretary-treasurer. Also Dr. J. E. Loggins,

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Galion, was elected delegate; and Dr. T. D. Sawyer, alternate.

The Society pledged its support to the program of the Heart Association and the Crawford County Heart Council.—Mart L. Helfrich, Jr., M. D., retiring secretary.

HARDIN

The local Sisters of Charity were hostesses when they gave their annual Christmas dinner party for members of the Hardin County Medical Society, their wives and friends at the San Antonio Hospital in Kenton.

Fourth District

(COUNCILOR: PAUL F. ORR, M. D., PERRYSBURG)

PUTNAM

The Putnam County Medical Society met in regular monthly session at Hotel Dumont, Ottawa, January 3.

Guest speakers were Dr. Henry B. Larzelere, cardiac surgeon of Toledo; Dr. John Dickie, cardiologist of Toledo; and Dr. Cavvalara, resident in chest surgery, Mercy Hospital, Toledo.

Dr. Larzelere discussed cardiac surgery, including surgical treatment of aortic insufficiency. Dr. Dickie outlined various medical treatments and their indications.

The following officers were chosen for 1956: President, Dr. Will W. Moody, Vaughnsville; Vice-President, Dr. James B. Overmeier, Leipsic; Secretary-Treasurer, Dr. Joseph J. McHugh, Ottawa; Corresponding Secretary, Dr. H. N. Trumbull, Columbus Grove. Also elected were: Dr. Milo B. Rice, Pandora, delegate; Dr. Donald B. Lucas, Columbus Grove, alternate; and Dr. Arthur P. Daniel, legislative committeeman.

The Putnam Society held its November meeting at Dumont Hotel also, where Dr. Bernard Glass, neurosurgeon of Lima, spoke on "Causes of Headaches."—H. N. Trumbull, M. D., Corresponding Secretary.

Sixth District

(COUNCILOR: CARL A. GUSTAFSON, M. D., YOUNGSTOWN)

COLUMBIANA

Seventy-five persons attended the joint Christmas dinner party of the Columbiana County Medical Society and Auxiliary on December 11 at the Valley Golf Club, near Columbiana.

MAHONING

Dr. Gabriel E. DiCicco, Youngstown, heads the Mahoning County Medical Society following the annual election on December 20 at the Elks Club of Youngstown.

Dr. Stephen Ondash is president-elect; Dr. A. A. Detesco, secretary; and Dr. Alexander Phillips, treasurer. Dr. Asher Randall was elected

delegate, with Dr. Fred Schlecht and Dr. Hugh Bennett and Dr. Paul Mahar, as alternates.

Dr. Charles W. Stertzbach was named editor of *The Bulletin* by Dr. DeCicco. The new president has served six years as secretary and two years as chairman of the annual postgraduate day committee, as well as being active in numerous other local organization affairs.

STARK

The annual meeting for 1955 was held at the Blenden Hotel in Canton on December 8 with dinner. The Honorable Frank Bow gave a talk on legislation affecting the practice of medicine and gave a word picture of conditions in other countries that he visited on his recent trip.

Dr. George Wilcoxon, of Alliance, assumed the duties as president. Dr. Ramsayer, retiring president, gave a brief review of accomplishments of the Society during 1955.

New officers elected are President-Elect, Dr. Robert E. Tschantz; Secretary-Treasurer, Dr. Murray W. Scott, Jr.; Censor, Dr. Graydon Underwood; Delegate, John R. Seesholtz; and Alternate, Dr. A. E. Boyles. Hold-over censors are Drs. Emerson Gillespie and Maurice Lieber; hold-over delegates are Drs. J. L. Yaharaus and R. E. Tschantz; and hold-over alternates, Drs. Ian B. Hamilton and William White.

For the January 12 meeting, Dr. Claude Beck and Dr. Bernard Brofman, of the Western Reserve University School of Medicine, discussed the subject, "Revascularization of the Heart."

SUMMIT

The Summit County Medical Society had as guest speaker at its December 6 meeting Marjorie Sheron, Ph. D., lecturer, legislative consultant and publisher of a paper known as the *Challenge to Socialism*. Her subject was "Your Future Under Social Security."

Seventh District

(COUNCILOR: ROBERT HOPKINS, M. D., COSHOCTON)

BELMONT

Gifts to be distributed to patients at Belmont Sanatorium were brought by members of the Belmont County Medical Society and Auxiliary to the December 15 meeting at the Belmont Hills Country Club.

TUSCARAWAS

The last meeting in 1955 of the Tuscarawas County Medical Society was held in the Union Hospital Auditorium in Dover. Dr. J. W. Hamilton, president, presided over the business session which consisted of election of officers and committee reports.

The officers and other key persons for 1956 are: Dr. H. E. Reed, president; Dr. Paul Hahn, president-elect and vice-president; Dr. C. R. Crawley, secretary-treasurer; Board of Censors—Drs. J. W. Hamilton, Van Epps and Pilloff; delegate, Dr. Hamilton; alternate, Dr. R. E.

Rinderknecht; legislative committeeman, Dr. Calhoun.

For the January 12 meeting of the Society guest speaker was Dr. Harold P. Roth, associate professor of medicine, Western Reserve University, and chief of the gastroenterology service at Crile Veterans Administration Hospital in Cleveland. He spoke on the subject, "Treatment of Peptic Ulcer and Complications."

Eighth District

(COUNCILOR: ROBERT S. MARTIN, M. D., ZANESVILLE)

GUERNSEY

Following are the officers for 1956 of the Guernsey County Medical Society: President, Dr. Thomas Frame; Vice-President, Dr. William Camp; Secretary-Treasurer, Dr. Russell Herman; Censor (3-year term), Dr. James Toland.

LICKING

Dr. James B. McMillen, of the Department of Pathology, Ohio State University College of Medicine, spoke on the subject, "Medical Legal Pathology," at the November 29 meeting of the Licking County Medical Society at the Mound-builders' Country Club, Newark.

Ninth District

(COUNCILOR: C. L. PITCHER, M. D., PORTSMOUTH)

SCIOTO

The December 12 meeting of the Scioto County Medical Society was held in the General Hospital Nurses' Home in Portsmouth. Dr. Jackson Herbert arranged a program on Streptococcal Infections.

Dr. Benjamin Felson, professor of radiology, University of Cincinnati College of Medicine, spoke on the topic, "Some of the Newer X-Ray Examinations," at the January 9 meeting of Scioto County Medical Society in Portsmouth.

Eleventh District

(COUNCILOR: H. T. PEASE, M. D., WADSWORTH)

LORAIN

Dr. Claude Beck, Cleveland, spoke on the subject, "Operation for Coronary Artery Disease," and discussed President Dwight D. Eisenhower's heart illness before the Lorain County Medical Society on December 13.

Dr. Thomas L. Smith, of Lorain, was elected president; Dr. Marion G. Fisher, Oberlin, vice-president; and Dr. Dennis A. Radefeld, secretary-treasurer. Dr. Radefeld succeeded Dr. L. H. Trufant who has held that position for 20 years and declined re-election.

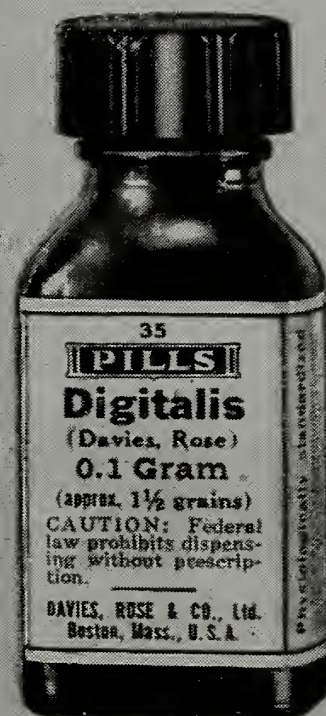
RICHLAND

The annual meeting of the Richland County Medical Society was held December 8 at the Fairway Club, near Mansfield.

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was held during which the following officers were elected to serve for 1956: President, Dr. P. O. Staker; Vice-President, Dr. Harry Wain; Secretary-Treasurer, Dr. C. F. Curtiss. Also elected were Drs. H. G. Knierim and Dr. L. D. Bonar, delegates; and Dr. C. O. Butner and Dr. D. W. Dewald, alternates.

Dr. Harry Wain gave a brief program on "The Story Behind the Word, or the Language of Medicine."

Hawaii Centennial

Physicians interested in a Spring tour to the Pacific Islands will be attracted by an invitation from the Hawaii Medical Association which has scheduled its centennial celebration and scientific congress, April 22-29. Several tours are scheduled in connection with the centennial. Additional information may be obtained from the Hawaii Medical Association, 510 So. Beretania St., Honolulu 13, Hawaii.

Activities of Woman's Auxiliary . . .

By MRS. GEORGE T. HARDING III, Chairman Publicity Committee, 430 E. Granville Road, Worthington, Ohio

President—Mrs. Karl F. Ritter, 1420 Shawnee Road, Lima

President-Elect—Mrs. William H. Evans, 291 Park Ave., Youngstown

Vice-President—Mrs. W. R. Gibson, 201 E. Water Street, Oak Harbor

Recording Secretary—Mrs. S. L. Meltzer, 2442 Dorman Drive, Portsmouth

Corresponding Secretary—Mrs. J. M. McBride, 808 Pears Ave., Lima

Treasurer—Mrs. Herbert Van Epps, 425 E. 15th St., Dover

Past-President—Mrs. A. Paul Hancuff, 3551 Maxwell Road, Toledo

ALLEN

Mrs. James W. Strong, women's page editor of *The Lima News*, was guest speaker for a meeting of the Auxiliary to Lima and Allen County Academy of Medicine. Her talk, following a luncheon in Shawnee Country Club, was illustrated with projected pictures shown by Mrs. Robert Hendershot. Mrs. Strong based her discussion on the lives and architectural contributions of five pioneer designers.

Mrs. J. W. Burke, president, conducted the meeting. Hostesses were Mrs. T. L. Edwards, Mrs. Vernon A. Noble and Mrs. W. E. Yingling. Mrs. Martin Sondheimer introduced the speaker. Reports were made by Auxiliary committee chairmen.

AUGLAIZE

The Medical Auxiliary of Auglaize County met with Mrs. E. F. Heffner at her home in Wapakoneta. During the business meeting Civil Defense and Community Health problems were discussed. The Auxiliary made contributions to the Retarded Children's Council of Auglaize County and the American Medical Association Education Fund.

The evening was concluded in making dressings for cancer patients, the dressings to be given to the Auglaize County Unit of the Cancer Society.

CLARK

November meeting of the Women's Auxiliary to the Clark County Medical Society was held in the Auditorium of the Ohio Fuel Gas Co. Building. Guests of the Auxiliary were the wives of interns at Springfield City and Mercy Hospitals. The program was a food demonstra-

tion by Betty Newton. Hostess for the meeting was Mrs. W. B. Williamson.

COSHOCTON

The Woman's Auxiliary to the Coshocton County Medical Society entertained their husbands with a covered dish supper on November 17, in the home of Dr. and Mrs. Floyd W. Craig of Coshocton. Supper was served to 20 and an evening of bridge followed.

CUYAHOGA

November 5 Cleveland doctors and their wives attended the yearly Chrysanthemum Ball. It was a dinner dance and proceeds went to the New Memorial Fund to which all may contribute in memory of physician fund. The fund is given to the American Medical Foundation for education of future doctors. Mrs. Paul Moore was general chairman.

DELAWARE

The Woman's Auxiliary to the Delaware County Medical Society held its annual Nurse Recruitment tea on November 6, in the social room of St. Peter's Episcopal Church. Invitations were issued to all freshmen girls in the city and county high schools interested in nursing.

Tea was served following the program by Mrs. F. M. Stratton and her committee.

ERIE

At the November luncheon meeting of the Woman's Auxiliary to the Erie County Medical Society, "Community Safety" was the program topic presented by a panel of Sandusky men, versed in various aspects of the problem. Dr. R. D. Fishell, health commissioner of the city and of Erie County; Charles F. Meyer, safety director of the GMC New Departure plant; and Capt V. F. Adcock, traffic director for the Sandusky Police Department, discussed the subject.

Mrs. J. R. Hart and Mrs. P. S. Lafollette were hostesses for luncheon. Mrs. Paul Vasquez was welcomed as a new member.

FAIRFIELD

Members of the Woman's Auxiliary to the Fairfield County Medical Society entertained

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with an afternoon tea November 10 in Mumaugh Memorial. Guests were wives of the members of Fairfield County Medical Society who were meeting in Lancaster.

The president of the Ohio State Woman's Auxiliary, Mrs. Karl Ritter of Lima, was present. The district director, Mrs. Richard Hille of Marietta, also attended.

In the evening the Auxiliary members met the Doctors at Lancaster Country club for cocktails and dinner. The tea was in charge of past presidents of the Fairfield County Auxiliary.

FRANKLIN

"A Neighborly visit to farms" is the way Mrs. George E. Peters described her recent visit to 13 countries of Free Europe at the meeting of the Woman's Auxiliary to the Columbus Academy of Medicine on November 21, which was held at the Columbus Gallery of Fine Arts.

GREENE

Psychological aspects in the development of a child's character were discussed by Dr. Minnie Steinhauer, Dayton, at a public meeting in Yellow Springs Elementary School Auditorium, November 11. The meeting was sponsored by the Auxiliary to the Greene County Medical Society and was attended by 100 persons.

Dr. Steinhauer is associated with the Dayton-Montgomery County Guidance Center.

HAMILTON

The Woman's Auxiliary to the Hamilton County Medical Society chose November 15 as the day for its trip to the Robert A. Taft Sanitary Engineering Center. Following the bus trip to the center, the Auxiliary convened in the auditorium for a business meeting. Mrs. Herbert J. Brinker, president, presided, assisted by Mrs. Kent E. Martin, vice-president.

Mrs. Joseph J. Podesta, program chairman of the day, introduced the speaker, Dr. Herbert W. Jackson, assistant chief of training programs in water supply and water pollution control at the Center. Refreshments were served at the conclusion of a tour of the Center.

The annual preholiday dinner and dance of the Woman's Auxiliary to the Hamilton County Medical Society was held December 3 at the Maketewah Country Club. This dance for members and husbands is given each year for the Auxiliary's educational and philanthropic fund. The proceeds from last year's dance provided financial assistance for students in four schools. The University of Cincinnati College of Medicine was the recipient of funds to be used at the discretion of the dean. The University of Cincinnati College of Nursing and Health received a contribution to be used toward a scholarship. Another scholarship was given to Seton School of Practical Nursing, Good Samaritan Hospital. The student aid fund of Central Vocational High School also received financial assistance. Each

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1. McLester and Darby: "Nutrition and Diet in Health and Disease," ed. 6, Saunders, p. 195. 2. McCay, C. M., in Lansing: "Problems of Aging," ed. 3, Williams and Wilkins, 1952, p. 193. 3. Sebrell and Hundley, in Stieglitz: "Geriatric Medicine," ed 3, Lippincott, 1954, p. 189.

year the philanthropic fund of the Auxiliary is divided in a similar manner.

Mrs. Vinton E. Siler and Mrs. Roy L. Kile were chairmen of the dinner and dance on December 3.

HARDIN

The annual Mistletoe Ball of the Hardin County Medical Auxiliary was held December 27 at the Elks ballroom. The proceeds from the affair were divided equally between Hardin Memorial and San Antonio hospitals.

KNOX

Twenty-two members of the Woman's Auxiliary of the Knox County Medical Society met Wednesday evening, November 30, at the home of Dr. and Mrs. George Imhoff with the doctors as guests.

Mrs. Julius Shamansky, president of the Auxiliary, presided. It was announced the Auxiliary would sponsor the organization of a Golden Age Club, for the recreation of older people in the community.

Mrs. James McLarnan was elected delegate to the Ohio State Medical Convention in Cleveland. Mrs. O. W. Rapp was named alternate.

LICKING

Thirty-six members of the Woman's Auxiliary to the Licking County Medical Association attended the annual casserole dinner, which is traditionally held in the home of the president. Mrs. Ralph Pickett, Granville Road, was the hostess.

A business meeting followed the dinner and those attending decorated Christmas stockings to be distributed by the American Red Cross at the Veterans Hospital in Chillicothe.

LORAIN

The Woman's Auxiliary to the Lorain County Medical Society held a guest meeting on November 17 in the Spring Valley Country Club in Elyria.

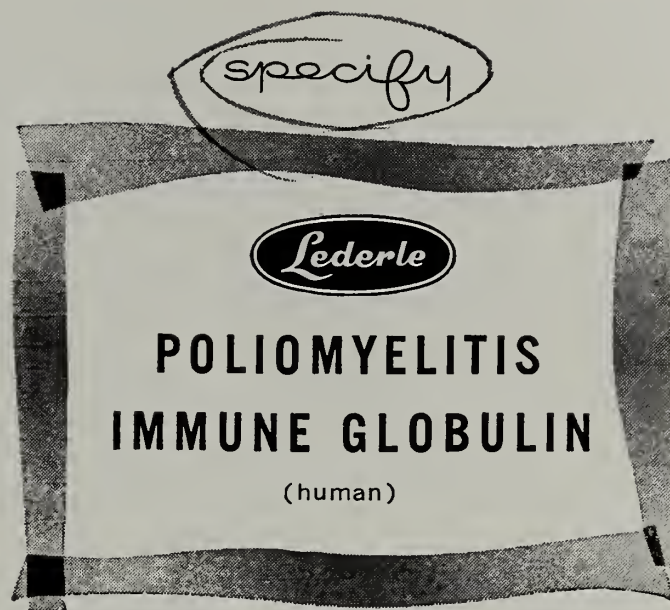
The Woman's Auxiliary was addressed by Dr. Ruth Robishaw-Rauschkolb, of Western Reserve University.

The Auxiliary took part in the exhibition of a "Health-Fair" held on November 3, 4, 5, at Holly Hall of the local YWCA.

The County Auxiliary exhibited a poster enumerating various projects of the Auxiliary in the County of Lorain. The magazine, *Today's Health*, was advertised and subscriptions sold. In line with the Health Fair one of the members of the Auxiliary gave a talk on Cerebral Palsy over the local radio network. Another member of the Auxiliary, who is also a County Welfare Council member, represented the Auxiliary at a Welfare Council meeting held at the "Health Fair."

LUCAS

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Williams and Defiance counties attended the meeting of the Fourth District of the Auxiliary to the Ohio State Medical Association November 9 in Bowling Green. Luncheon was served in the Charles Restaurant. Mrs. R. N. Whitehead, president of the district, was hostess. The state president, Mrs. Karl Ritter, and vice-president, Mrs. W. R. Gibson, spoke. Mrs. John D. Dickie is the Fourth District director.

Mrs. Rollin Kuelheler, member of the Auxiliary, was elected to a seat on the school board in Toledo. Mrs. Frederick Posgood, also a charter member of the Lucas County Auxiliary, was Sylvania Township's choice for its school board. A Baby Sitters' Course is a project of the Toledo YMCA approved by the Medical Auxiliary.

Mrs. William Bronser attended the Citizen's Day Care recognition breakfast as representative of the Lucas County Auxiliary. A meeting on November 15 featured a talk by John H. McNerney, president of the board of trustees of Maumee Valley Hospital and secretary-treasurer of the Owens-Illinois Glass Co.

On November 16, Dr. Joseph Duty spoke in the nurses lounge of Toledo State Hospital on "Various Types of Mental Illnesses" at a meeting of the Auxiliary's health education group. Other meetings for that week included the Musical Masqueraders Choral Group gathering at the Hope Lutheran Church, and the leadership training and public speaking session at the academy building.

The Auxiliary gave an annual tea for the Future Nurses Clubs on November 6 in the Academy Building. The Future Nurses Clubs are organized in the high schools.

Barbara Hart, who received a 3-year scholarship to Mercy Hospital school of nursing from the Auxiliary, was guest of honor at the tea. The Auxiliary had a benefit dance for its nurse recruitment fund November 12 at the Toledo Club. The women recruited their husbands for a floor show at intermission. Mrs. C. S. Kellogg was general chairman of the dance.

Study groups of the Auxiliary which met in November included the English Study Group and the live issues afternoon and evening groups.

MAHONING

The nurses' scholarship fund dance at which the Woman's Auxiliary to the Mahoning County Medical Society entertained the night of November 12 at Squaw Creek Country Club attracted over 250 guests, including area doctors, resident interns with their wives and guests. Mrs. Harold Chevlen and Mrs. David Brody, chairman and co-chairman of the committee, were in charge of the successful affair.

RICHLAND

More than 100 prespective nurses were guests of the Woman's Auxiliary to the Richland County Medical Society on November 7 when it presented Miss Virginia Miller, a Columbus

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model and nurse in a talk: "Nursing vs. Modeling." Members of the Auxiliary who are nurses modeled the student attire of their respective hospitals.

Approximately 60 of the high schoolers attended.

SCIOTO

At the November meeting of the Woman's Auxiliary of Scioto County Medical Society, doctors' wives viewed Dr. O. R. Micklethwait's large collection of cloisonné and glass. Mrs. Wells McCann, legislation chairman, conducted a program on medical legislation, entitled "What Congress Did in 1955 and What Is the Outlook for 1956."

Mrs. Clyde M. Fitch reported plans are being made to start a nurse's aid training class again in February. Last year, 88 students were trained in a similar course. Mrs. Fitch also announced the 46 girls from Scioto County entered the nursing field this fall.

STARK

The Stark County Auxiliary honored forty-seven new members at its first new membership tea in three years. It was held at the home of Mrs. Francis Boyer, president of the Auxiliary, on September 26.

The annual Benefit Dance was held November 5. Proceeds from the dance totaled \$1,155.

Fourteen student nurses are training in Canton Hospitals this year under the Auxiliary's Scholarship Loan Fund.

Future Nurse's Clubs are being sponsored for their second year in six local high schools with a membership of over 300 students. Sixty Auxiliary members are helping with this project under the direction of Mrs. Mark Herbst.

The new project for the year is the establishment of Hospitality Carts for Aultman and Mercy Hospitals. They are being purchased, equipped and staffed by Auxiliary members.

TRUMBULL

More than 500 doctors and their wives attended the Sixth Councilor District Postgraduate Day held in Warren, October 26, (Mahoning, Columbiana, Summit, Stark, Portage, and Trumbull) at the newly dedicated Packard Music Hall.

The wives registered and had coffee served to them at the Methodist Church. Lunch was served here, following which they were entertained by the Trumbull Memorial Hospital Student Nurses Choral Group. Mr. Leo Brown, chairman of the Public Relations Committee of the American Medical Association, was the speaker of the afternoon. Brief messages came from the State President, Mrs. Karl Ritter of Lima, who called this the best attended meeting in this district; State President-Elect, Mrs. W. H. Evans of Youngstown; Mrs. Craig Wales, 6th District Director; Mrs. Morton Crow of Warren, member of the State Board; and Mrs. Edward Bauman,

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President of the Trumbull County Medical Auxiliary.

TUSCARAWAS

The September meeting of the Tuscarawas County Auxiliary was a planning meeting. It was decided that the primary money-making project of the year would be a lecture series for the community. Jean Woodward is chairman of this committee.

The first nurse to be sponsored by Tuscarawas was announced. She is to train at Charity Hospital in Cleveland.

The Auxiliary is active in radio programs, the Gray ladies and Ground Observer Corps and in the Orthopedic Clinic.

Dr. Karnosh of Cleveland spoke at the Mental Health dinner in October.

Members attended the District meeting in Steubenville in October.

The November meeting was held in the afternoon. Mrs. Swearinger of Canton gave a talk on the Air Filter Center.

VAN WERT

Mrs. F. A. McCammon of Webster Avenue was hostess at a meeting of the Van Wert County Medical Auxiliary in November. Mrs. E. W. Burnes and Mrs. J. W. Cox presented the program which dealt with various systems of treatment of diseases. Current legislature also was presented by Mrs. Burnes.

The local Auxiliary was invited to attend the Mercer County Auxiliary meeting with Celina unit host for a civilian defense meeting for Auglaize, Van Wert and Mercer County Auxiliaries. Mrs. Warren F. Mills, Third District director of the Ohio State Medical Auxiliary, and Mrs. H. L. Mikesell of West Liberty were guests at the meeting at the McCammon home.

The Christmas meeting was a luncheon held at Whitehall Inn. Mrs. E. W. Burnes was in charge of details. A social hour followed in the home of Mrs. J. R. Jarvis.

WASHINGTON

Ninety Senior girls from Marietta schools attended the annual nurses' tea sponsored by the Washington County Woman's Auxiliary, in Marietta Memorial Hospital on November 2. A film, "Woman in White," was shown.

Ohio Conference on Human Nutrition Scheduled at OSU, March 2-3

The Third Ohio Conference on Human Nutrition will be held at the Ohio Union, OSU Campus on Friday and Saturday, March 2 and 3. Its program is designed to be of especial interest to nurses, physicians, nutritionists, dietitians, teachers, and others interested in health and nutrition.

The conference will open at 1:30 p. m. on Friday, March 2, with a discussion of the major nutrition problems of the U. S. today by James M. Hundley, M. D., of the National Institutes of

Cook County Graduate School of Medicine

INTENSIVE POSTGRADUATE COURSES

STARTING DATES—WINTER-SPRING, 1956

SURGERY—Surgical Technic, two weeks, Mar. 19, Apr. 2. Surgical Anatomy & Clinical Surgery, two weeks, Mar. 5. Surgery of Colon & Rectum, one week, Apr. 9, May 7. General Surgery, two weeks, Apr. 23. Basic Principles in General Surgery, two weeks, Apr. 9. Gallbladder Surgery, ten hours, Apr. 9. Fractures & Traumatic Surgery, two weeks, Mar. 12. Varicose Veins, ten hours, Mar. 19, April. 30.

GYNECOLOGY—Office & Operative Gynecology, two weeks, Mar. 12, April 16. Vaginal Approach to Pelvic Surgery, one week, Mar. 5, Apr. 30.

OBSTETRICS—General and Surgical Obstetrics, two weeks, Mar. 26, May 7.

MEDICINE—Internal Medicine, two weeks, May 7. Electrocardiography & Heart Disease, two-week basic course, Mar. 12. Gastroscopy, forty-hour course, Mar. 19. Dermatology, two weeks, May 7.

RADIOLOGY—Diagnostic X-Ray, two weeks, Apr. 30. Clinical Use of Radioactive Iodine, one week, Apr. 2. Clinical Uses of Radioisotopes, two weeks, May 7.

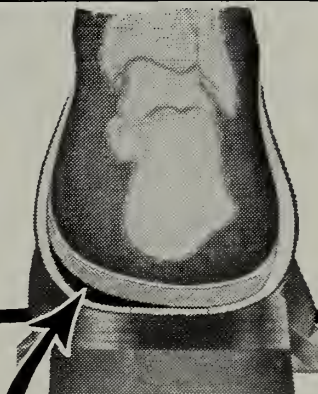
PEDIATRICS—Intensive Review Course, two weeks, May 14. Neurological Diseases: Cerebral Palsy, two weeks, June 18.

UROLOGY—Two-Week Course, Apr. 16. Cystoscopy, Ten Days, by appointment.

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Health. Other major speakers and their topics for the afternoon and evening program include:

"Nutrition in Adolescence," Joseph Johnston, M. D., pediatrician-in-chief, Henry Ford Hospital, Detroit.

"Modern Food Processing Methods and How They Affect Nutrition," George Garnatz, Ph. D., Kroger Foundation, Cincinnati.

"Sense and Nonsense About Obesity," William Parson, M. D., Dept. of Internal Medicine, University of Virginia.

The Saturday morning program will include three concurrent discussion groups holding repeat sessions to provide everyone with the opportunity of attending two of the three. Subjects and their discussion leaders are as follows:

"Trace Elements in Nutrition," J. B. Brown, Ph. D., director, Institute of Nutrition and Food Technology, OSU.

"Nutrition Problems of the Older Age Groups," William Ashe, M. D., chairman, Dept. of Preventive Medicine, OSU.

"Nutrition Problems of the School-Age Child," Mrs. Ethel Patterson, M. S., district nutrition consultant, Ohio Dept. of Health.

The meeting will close at noon with a luncheon at which George J. Hamwi, M. D., Associate Professor of Medicine, OSU, will give the group a "forward look" in a discussion of the relationship of nutrition to medicine.

The conference is sponsored by the Ohio Nutrition Committee, the Ohio Department of Health, and the Graduate School and Institute of Nutrition and Food Technology of the Ohio State University. All professional persons interested in nutrition are invited.

Appointments Approved by The Ohio Senate

Among the appointments approved by the Ohio Senate during the Special Session of the State Legislature held in Columbus, January 16-18, were the following:

Advisory Council to the Division of Mental Hygiene, Department of Mental Hygiene and Corrections, by Dr. John D. Porterfield, Director of the Division:

Calvin L. Baker, M. D., Columbus for term ending September 30, 1956.

Harry E. LeFever, M. D., Columbus, for term ending September 30, 1956.

Louis J. Karnosh, M. D., Cleveland, for term ending September 30, 1957.

George T. Harding, M. D., Worthington, for term ending September 30, 1958.

The Senate also approved the appointment by Governor Frank J. Lausche of Fred W. Phillips, M. D., Zanesville, as a member of the Advisory Council of the Board of Nursing Education and Nurse Registration for a term ending January 1, 1959.

INDEX TO ADVERTISERS

Abbott Laboratories	196 - 197
Ames Company, Inc.	134
Ann Arbor School	213
Appalachian Hall	132
arlington-funk laboratories, division of U. S. Vitamin Corporation	114
Ayerst Laboratories, Inc.	187
Baker Laboratories, Inc.	118
Burroughs Wellcome & Co. (U.S.A.) Inc.	119
Ciba Pharmaceutical Products, Inc.	205
Coca-Cola Company	128
Cook County Graduate School of Medicine	217
Davies, Rose & Co., Ltd.	209
Desitin Chemical Company	111
Endo Products, Inc.	126
Foot-so-Port Shoe Co.	217
Geigy Pharmaceuticals, Inc.	136
General Electric Company, X-Ray Dept.	191
Harding Sanitarium	130
Hoffmann-LaRoche, Inc.	Insert between Pages 124 - 125
Knox Gelatine Co., Inc.	179
Lakeside Laboratories, Inc.	109
Lederle Laboratories	174 - 175, 213
Lilly, Eli, and Company	140
Luzier's, Inc.	205
MacAllister Laboratory	207
Magnetic Springs Foundation	195
Mayo Clinic and Mayo Foundation	200
McMillen Sanitarium	132
Mead Johnson & Company	Back Cover
Medfoam Products Co.	214
Medical Protective Company	216
National Drug Company, The	124
Neil Training School	205
New York Polyclinic Medical School	135
Oak Ridge Sanatorium	130
Parke, Davis & Company	220 and Inside Back Cover
Pfizer, Chas. & Co., Inc.	113, 215
Resthaven	207
Riker Laboratories, Inc.	201
Rocky Glen Sanatorium	203
Sanborn Company	120
Sawyer Sanatorium	133
Schering Corporation	116 - 117, 138 - 139
Scroggins, Clayton L., Associates (Medical-Dental Management)	128
Searle, G. D. & Company	189
Sharp & Dohme, Inc.	121, 131, 193
Smith, Kline & French Laboratories	129
Squibb, E. R. & Sons, Division of Olin- Mathieson Chemical Corporation	137
Stoneman Press	135
Tutag, S. J. & Company	203
Upjohn Company	127, 207
U. S. Vitamin Corporation	114
Vitamin Food Co., Inc.	212
Wendt-Bristol Company	216
Wesnoca	207
Wickhaven Sanitarium	205
Windsor Hospital, Inc.	203
Winthrop-Stearns, Inc.	125
Wyeth, Inc.	211

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COMING MEETINGS

Ohio State Medical Association, Annual Meeting, Cleveland, April 10-12.

American Medical Association, Annual Session, Chicago, June 12-14.

American Congress of Physical Medicine, 34th Annual Session, Atlantic City, September 9-14.

American Goiter Association, Annual Meeting, Drake Hotel, Chicago, May 3-5.

Cleveland Society of Obstetrics and Gynecology, Cleveland University Club, April 9, an invitational meeting for Ohio specialists in field.

General Practice Postgraduate Course, Cleveland Chapter of the American Academy of General Practice with the Frank E. Bunts Educational Institute, Cleveland, February 8 and 9.

1956 Industrial Health Conference, Convention Hall, Philadelphia, Pa., April 21-27.

Ohio State Heart Association, Annual Meeting, Cleveland, April 9.

Ohio State University, Postgraduate Course in Ophthalmology, March 5 and 6, Ohio Union Building, OSU Campus.

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OBSTETRICS & GYNECOLOGY: Excellent opportunity for young physician in northeastern Ohio. Box 856, c/o Ohio State Medical Journal.

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INTERNIST, 4 yrs. training as resident in medicine; age 32; married and 3 children; desires position in clinic or desirable location with group or another doctor where he can practice internal medicine. Box 860, c/o Ohio State Medical Journal.

Jefferson Medical Alumni Reunion

A get-together has been arranged for alumni of Jefferson Medical College, their wives and guests who will attend the 1956 Annual Meeting of the Ohio State Medical Association, Cleveland, April 10-12. It will be held on Tuesday, April 10, at the Statler Hotel, Cleveland. The event will start with a social hour at 7 o'clock, followed by dinner. After dinner there will be brief speeches about Jefferson Medical College.

Those planning to attend can assist the planning committee, by notifying: Dr. Russell S. McGinnis '21, 10515 Carnegie Ave., Cleveland, Ohio, by mail.

The 34th annual scientific and clinical session of the American Congress of Physical Medicine and Rehabilitation will be held September 9-14 at The Ambassador, Atlantic City, N. J. Details may be obtained from the Congress at 30 N. Michigan Ave., Chicago 2, Ill.



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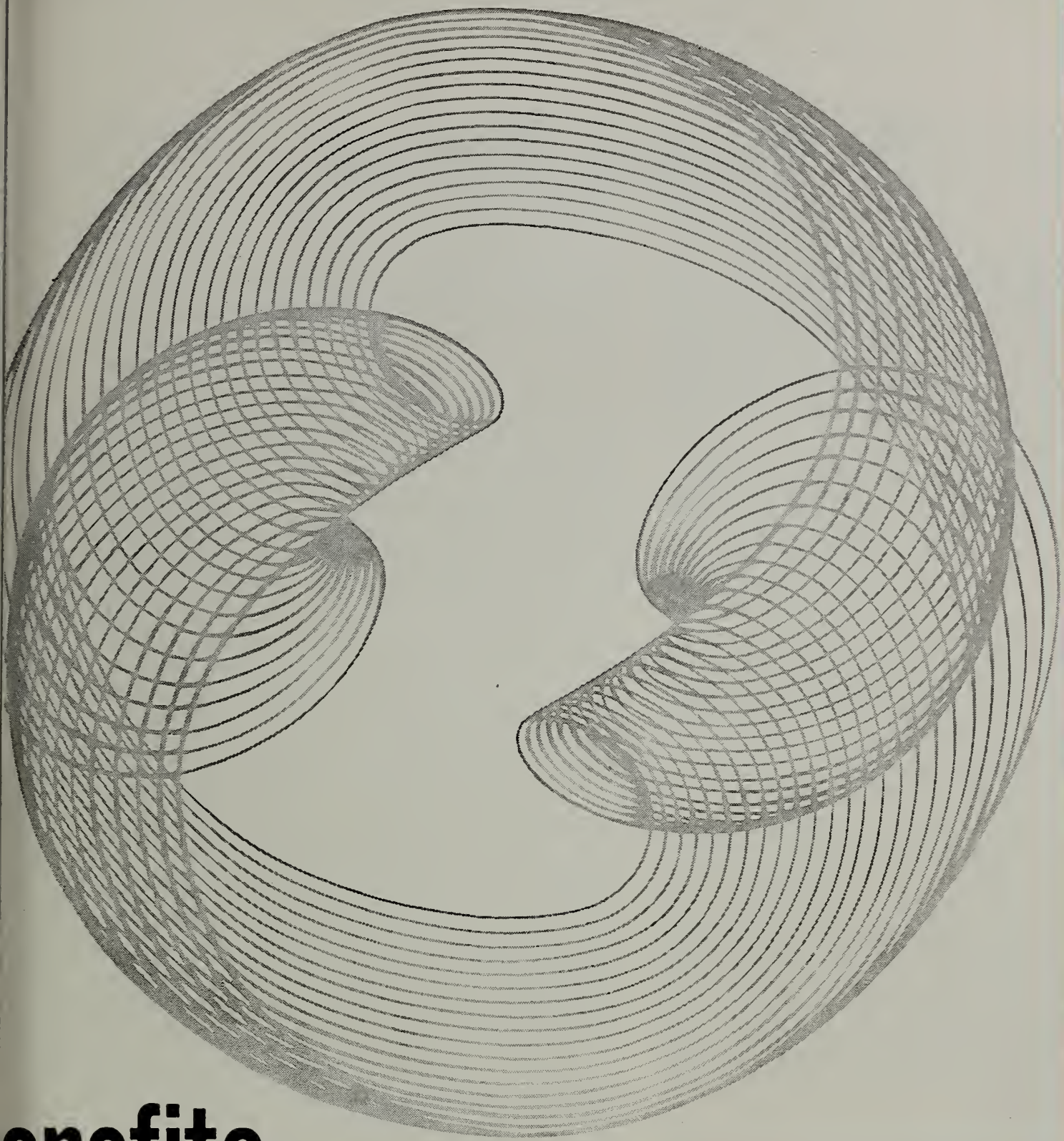
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The Physician's Bookshelf

By JONATHAN FORMAN, M. D.

Muscular Dystrophy—Proceedings of The Third Medical Conference, (Apply Muscular Dystrophy Associations of America, Inc., New York, N. Y.). Contains six symposia, four dealing with basic biochemistry and physiology of muscles, and two dealing with the clinical aspects of the dystrophy problems.

A Textbook of Medicine, edited by Russell L. Cecil, M. D., and Robert F. Loeb, M. D., (\$15.00. Ninth Edition. *W. B. Saunders Company, Philadelphia 5, Pa.*). This successful text appears with a score or more of new sections and 58 new treatises on old topics by new authors.

New and Nonofficial Remedies—1955, issued under direction of the Council on Pharmacy and Chemistry of The American Medical Association, (\$3.35. *J. B. Lippincott Company, Philadelphia 5, Pennsylvania*). Contains descriptions of the articles which stand accepted by the Council on January 1, 1955.

Modern Drug Encyclopedia and Therapeutic Index, edited by Marion E. Howard, M. D., (\$12.00. Sixth Edition. *Drug Publications, Inc., 49 West 45th St., New York 36, N. Y.*). This new edition has been radically changed and improved. Hundreds of old products no longer promoted by their manufacturers have been deleted and legend drugs, exempt narcotics, and a comprehensive generic name index have been added. The book has been enlarged to 1500 pages to include expanded descriptions of new drugs with cautions.

Talking with Patients, by Brian Bird, M. D., (\$3.00. *J. B. Lippincott Company, Philadelphia 5, Pennsylvania*). Of all the technical arts which increase the physician's power of observation, none come close in value to the skillful use of the spoken words—words of his own and the words of his patient. Words still remain the main diagnostic tool. This pocket book contains hundreds of thought provoking suggestions on how talking with the patient can be more helpful.

Ageing—General Aspects, Vol. 1, edited by G. E. W. Wolstenholme, and Margaret P. Cameron, (\$6.75, for The Ciba Foundation by *Little, Brown & Company, Boston 6, Mass.*). Proceedings of International Colloquia on Ageing, intended to be a general exploration and appreciation of the present position in regard to opinion and experiment on the processes associated or directly connected with ageing.

The Biologic Effects of Tobacco, edited by Ernest L. Wynder, M. D., (\$4.50. *Little, Brown & Company, Boston 6, Mass.*). An evaluation of tobacco and tobacco smoke to human health,

their effects upon the cardiovascular system, neoplastic diseases, the gastrointestinal tract and allergic phenomena. It represents a sincere attempt to get at the facts by top-flight authorities.

Induced Abortion on Psychiatric Grounds: A Follow-up Study on 479 Women by Martin Ekblad, (Ejnar Munksgaard, Norregade 6, Copenhagen, Denmark). In this supplement to *Acta Psychiatrica et Neurologica Scandinavica*, the author reports a follow-up on 479 women who had been granted legal abortion in Sweden on psychiatric grounds. According to the Swedish Abortion Act which has been in force since 1946, legal abortion may be granted on medical, special, social-medical, humanitarian, or eugenic indications. The number being performed under this act in 1951 had increased 57.5 legal abortions to every 1,000 children born alive. The results indicate that sterilization of these women was performed without any more pronounced unfavorable psychic sequelae and may be recommended more frequently than had been the case in Sweden. This is especially true where the women themselves were eager to be sterilized. Women who do not want to be sterilized or who give their consent at the time in order to get an abortion, or who have been persuaded by others to submit to sterilization, are a greater risk for unfavorable psychiatric sequelae.

Perinatal Mortality in New York City, by Schuyler G. Kohl, M. D., Dr. P. H., (\$2.50. *Harvard University Press, Cambridge, Mass.*). This volume contains the results of an intensive study of perinatal deaths occurring in New York City in 1950, conducted by a Subcommittee on Neonatal Mortality of the Committee on Public Relations of the New York Academy of Medicine. The work is published in book form with the hope that illumination of the problem will result in reducing perinatal mortality, in the same manner as the Committee's earlier publication contributed to the reduction of Maternal Mortality (Hooker, R. S., *Maternal Mortality in New York City, 1933*). The Committee thoroughly investigated 955 prenatal, natal and neonatal deaths (including premature babies). A vast amount of information was collected and compiled systematically in every case. From this information the Committee evaluated the cases and, after determining as accurately as possible the causes of perinatal mortality, the extent of preventability was determined. Responsibility for perinatal mortality was assessed under eight headings (inadequate prenatal care, error in medical judgment, unqualified attendant, unsatisfactory pediatric care, etc.). Based on final analysis of

statistics obtained through the study, 24 conclusions were obtained; one revealed 35 per cent of the deaths were preventable! Facts and tables are well arranged and provide a wealth of information on the perinatal mortality study. The book should be valuable particularly to a practitioner who is interested in obstetrics or pediatrics, and should provide excellent guidance to a committee seeking to enter into or improve a perinatal mortality study.

Foetal, Infant and Early Childhood Mortality, Vol. I The Statistics, United Nations, New York. (*Columbia University Press, New York 27, New York*). The present volume is designed to indicate the sources of statistical information on this subject, the extent and limitations of data available, and the problems involved in improving the statistics, and to examine some of the problems of analyzing and interpreting these data.

Biology and World Health, by Madelene P. Grant, (\$3.50. *Abelard-Schuman Press, 381 Fourth Avenue, New York 16, N. Y.*). All of the basic facts of biology are presented dramatically with relation to the world around us, including energy and the "Web of Life"; how worms affect us; our relation to microbes and viruses; what influences health and how health can be measured.

Introduction to Paristology, by Asa C. Chandler, (\$8.50. 9th Edition. *John Wiley & Sons, Inc., New York 16, N. Y.*). In this edition, greater emphasis has been placed on the section dealing with the parasitic diseases that are of increasing current interest in the world. The increasing danger of introduction of parasites from foreign countries makes this book of greater value.

Community Adult Education, by Robert H. Snow, (\$3.50. *G. P. Putnam's Sons, New York 16, New York*). Methods of organizing and maintaining learning opportunities for men and women.

Occupational Abstracts: Bacteriologist, Clinical Psychologist, Dental Assistant, Dietitian, Optometrist, Receptionist, School Psychologist, Speech Therapist, Optician, X-Ray Technician, Registered Nurse, Psychiatric Social Worker, Medical Record Librarian, Pathologist, Orthoptic Technician (Separate pamphlets on occupations listed, 50¢ each. *Personnel Services, Inc., Sydney F. Austin, Editor, Peapack, N. J.*). A composite summary of the available information for all those who are interested.

Feeding Your Child, by Samuel M. Wishik, M. D., (\$3.50. *Doubleday & Company, Garden City, N. Y.*). A practical reassuring guide that answers the everyday questions related to feeding from infancy through the school years.

Diseases of the Nervous System, by F. M. R. Walshe, M. D., (\$7.00. 8th Edition. *Williams & Wilkins Company, Baltimore 2, Md.*). Eight

editions in 15 years speaks for the quality of this text. The author gives us the benefit of his critical judgment of much that is new but may be neither substantiated nor true.

We Went to the Doctor, by Carl Memling, (\$2.50. *Abelard-Schuman Press, 381 Fourth Avenue, New York 16, N. Y.*). This delightful story fills a gap in children's literature and makes an adventure of the experience.

Demonstrations of Physical Signs in Clinical Surgery, by Hamilton Bailey, (\$8.00. 12th Edition. *Williams & Wilkins, Baltimore 2, Md.*), is what its name implies a series of demonstrations by means of pictures. In these days of laboratory medicine this book serves a useful purpose because physical examination will always remain basic to physical diagnosis.

The Prevention of Occupational Skin Diseases, by Louis Schwartz, M. D., (Apply. *Association of American Soap and Glycerine Producers, Inc., 295 Madison Avenue, New York 17, N. Y.*). This booklet is being supplied to industry by companies that produce and sell skin cleansing products and are members of the Association. The author has supplemented the findings of his own long experience with information provided by technical committees of the Association. In this way has been produced a booklet of great value to our profession.

Morbidity in The Municipal Hospitals of the City of New York, by Marta Fraenkel, M. D., and Carl L. Erhardt, (\$4.50. *Russell Sage Foundation, New York 22, N. Y.*). This is a report of an exploratory study in Hospital Morbidity Reporting. The scarcity of intelligence on volume and type of disease among the city's residents has been a real handicap in planning of both publicly and privately supported health and hospital services.

The Story of Medicine, by Arthur L. Murphy, M. D., (\$3.00. *Bouregy & Curl, Inc., 22 East 60th Street, New York 22, N. Y.*). Dr. Murphy's book provides an excellent background against which to present the present-day developments in matters of health for medical students and the nonmedical reader. Thirty-nine delightful essays of great value.

Tumor-Host Studies, by Kenneth G. Scott, and Chin-tzu Peng, (\$0.75. *University of California Press, Berkeley, Calif.*). A study of the physiological and pharmacological action of an iodide-trapping substance formed in tumor-bearing animals.

Nutrition Sourcebook, by Oliver E. Byrd, M. D., (\$7.50. *Stanford University Press, Stanford, California*). Presents a representative sample of the current professional journal literature in the field of nutrition over a period of approximately ten years. Abstracts of 400 articles screened and selected from over 4,000.



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The Ohio State Medical Journal

Published under the direction of The Council for and by the members of The Ohio State Medical Association, a scientific society, non-profit corporation, with a definite membership, for scientific and educational purposes.

Vol. 52

March, 1956

No. 3

JONATHAN FORMAN, M. D., *Editor*

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R. GORDON MOORE,
Asst. Managing Editor

The Present Status of Carcinoma of the Lung*

EARLE B. KAY, M. D., and FREDERICK S. CROSS, M. D.

THERE has been considerable pessimism of late because of the increasing incidence of cancer of the lung. The depressing aspect of this problem has been the fact that all of a sudden carcinoma of the lung was found to be the most common carcinoma at a time when all of the previous medical writings considered it a rare condition. It was further depressing to note that its increasing incidence had gone undetected until hundreds of patients had arrived at a stage in their disease when the diagnosis was obvious and treatment hopeless.

INCREASING INCIDENCE

The increasing incidence of bronchogenic carcinoma was ably demonstrated by the studies of Boyce¹, who in an analysis of all hospital records at Charity Hospital in New Orleans from 1910 to 1952, found no instance of bronchogenic carcinoma from 1910 to 1927; 21 patients with this condition between 1928 and 1934; and the amazing increase in incidence between 1947 and 1952 of 942 patients with bronchogenic carcinoma. Many other reports are of a similar nature but not quite so striking.

FACTORS CONTRIBUTING TO THE ETIOLOGY

Similar studies have also been made in reference to the increasing incidence of cancer in other organs. Although such studies have shown an increase in the incidence of malignancy in general, this relative increase is in no way comparable to the marked increase noted in bronchogenic carcinoma. There is no question that excessive smoking, the inhalation of certain irritant

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gases and the close contact with radioactive ores are predisposing factors in individuals who may have a hereditary predisposition to malignancy.

The educational and research efforts in behalf of this disease are becoming more and more effective, and are already beginning to bear fruit. Fewer people are smoking. Those who smoke are for the most part smoking less or have changed to filtered cigarettes. The safety of filtered cigarettes remains to be proven. This trend is particularly noticeable among doctors and especially among chest physicians and surgeons. There is undoubtedly an individual variation in reference to smoking, but if smoking can be limited to less than one package a day in reference to cigarettes, little correlation between smoking and the incidence of bronchogenic carcinoma would be noted. We did not attempt to correlate the degree of smoking and bronchogenic carcinoma in this series but we did note that the majority of the male patients with carcinoma of the lungs smoked one or more packs of cigar-

*From the Surgical Services of St. Luke's and St. Vincent Charity Hospitals, Cleveland, Ohio.

Submitted February 21, 1955.

ettes a day and only six male patients were non-smokers.

CONTROL MEASURES

Industries are increasingly employing ventilation systems to reduce the hazard of inhalation of irritant gases. Cities are giving more thought to smoke control, and workers in radioactive ores are being afforded protection.

Physicians are becoming more and more aware of the prevalence of bronchogenic carcinoma, its similarity to other bronchopulmonary diseases, and the steps necessary for its early detection and diagnosis. Mass roentgen surveys have proven the value of the routine chest x-ray in detecting carcinoma. Physicians no longer rely on the old textbook descriptions of bronchogenic carcinoma based mainly on the far advanced case. The motto has changed so that any pulmonary lesion is now considered malignant rather than tuberculous until proven otherwise.

This awareness of the problem by the public and their physicians is already reflecting itself in present-day statistics. As recently as 1944 a report from Brompton Hospital in England² showed that only 7.5 per cent of 996 patients seen were still in an early enough stage for the carcinoma to be resected. In another report in 1946 by Ochsner, DeBakey, and Dixon,³ only 13.4 per cent of 2,034 patients collected from the literature were early enough to have their carcinomas removed by operation, the other 86.6 per cent being seen too late for surgical treatment. Surgeons are now reporting an increase in the number of patients being seen early enough in their disease to allow resection. There is still much to be desired that only the continued efforts of everyone can help, but it is at least satisfying that some progress is being made in this direction.

To illustrate the basis of our enthusiasm for the continued support of the educational efforts and the necessity for the earlier and earlier detection of bronchogenic carcinoma, we would like to present our experience with 667 carcinomas of the lung treated between 1946 and 1954 inclusive. The discussion is confined to 504 private patients of this group in whom the follow-up is complete.

RESULTS OF SURGERY

Group I includes 214 patients treated between 1946 and 1950; Group II deals with 290 patients treated between 1950 and 1954.

There was an average duration of symptoms of six months in Group I as compared to four months in Group II. In Group I, 121 patients (57 per cent) were obviously inoperable when first seen for consideration for operation; 93 patients (43 per cent) were explored; and 47 (22 per cent) had pulmonary resections. There were nine postoperative deaths (19 per cent), eight of which resulted from cardiorespiratory and renal complications in poor risk patients. In only 17 patients (36 per cent) could the pneumonectomies

be considered therapeutic. That is, as far as could be ascertained at the time of the operation the carcinoma was limited to the confines of the lung and there was no gross evidence of mediastinal glandular involvement.

In the other 30 patients (64 per cent) upon whom pulmonary resection was performed, the carcinoma had either extended to the mediastinum, chest wall, or there was gross evidence of mediastinal lymph node involvement. Three of the 17 patients, upon whom therapeutic pneumonectomies were performed, died postoperatively. Of the remaining 14 patients, 10, or 70 per cent, are alive from 5 to 9 years afterwards, which aptly demonstrates that if the carcinoma can be detected early enough while limited to the confines of the lung, the prognosis following resection is excellent.

To further illustrate the growing awareness of the public and their physicians to this problem, there have been 290 patients with bronchogenic carcinoma seen between 1950 and 1954. The exploratory rate has increased to 47 per cent (137 patients) and the resectability rate has increased from 22 to 33 per cent (96 patients) or an increase of approximately 25 per cent over that reported just 10 years ago. It is most encouraging to note the proportionate increase in the number of resections considered to be therapeutic as contrasted to the palliative group. This has increased from 36 per cent in the Group I to 53 per cent in Group II.

The operative mortality has fallen from 19 per cent in Group I to 12 per cent in Group II. The operative mortality following pulmonary resection is a variable factor dependent largely upon each individual surgeon. The technical factors responsible for postoperative deaths in experienced hands is a very small figure. The mortality rate is largely dependent upon how severe a risk the surgeon is willing to accept for surgery in a patient who otherwise would die from his carcinoma unless surgical removal of the cancer is attempted. It is further encouraging to note that in Group II, 42 patients are now alive from one to four and one-half years following resection. These 42 patients would represent approximately 44 per cent of the patients resected or 82 per cent of the therapeutic resections.

The results of pulmonary resection are sufficiently encouraging in those patients fortunate to be diagnosed early enough to be resected to stimulate all physicians to take a very aggressive attitude in its early recognition.

EARLY MANIFESTATIONS

The purpose of this paper is to demonstrate the early manifestations of bronchogenic carcinoma, its similarity to other chest lesions, the difficulties entailed in the differential diagnosis, and the program necessary to either establish a diagnosis or be followed in the proper handling of these patients. Only by constant surveillance

of our patients can we hope to avoid the tragic consequences of a mistaken diagnosis. One should be suspicious of all pulmonary lesions, not only to the extent of passively contemplating the possibility of malignancy being present, but to the extent of actively determining the etiology of such lesions by the proper diagnostic tests.

Bronchogenic carcinoma may simulate chronic bronchitis, bronchopneumonia, virus pneumonia, unresolved pneumonia, pulmonary suppuration, tuberculosis, asthma, lung abscess, influenza, interlobar effusion, aortic aneurysm, the lymphoblastomas, and cystic disease, not only clinically but they may also be indistinguishable roentgenologically.

The classical signs, symptoms, and roentgen manifestations of advanced bronchogenic carcinoma are familiar to all. Very few patients present a clear cut picture early in the disease. Some patients have no symptoms referable to the chest whatsoever.

In the differential diagnosis of pulmonary diseases, one must remember that the development, persistence, or exacerbation of an irritative cough may be the first and only sign or symptom of cancer and not the result of a cold or smoking. The presence of dyspnea and wheezing may be caused by partial bronchial occlusion by a tumor as well as by asthma. Bronchopneumonia or unresolved pneumonia may be caused by malignant bronchial obstruction, atelectasis, and infection. The presence of cavitation may be due to a necrotizing carcinoma or an abscess distal to an obstructed bronchus and not due to tuberculosis. If these possibilities are kept in mind, one will more likely recommend further diagnostic procedures in the attempt to determine the etiology.

MANAGEMENT OF SUSPICIOUS PULMONARY LESIONS (THE QUESTIONABLE CASE)

It is gratifying to note the increasing number of patients being referred for an opinion because a fluoroscopic or routine x-ray examination of the chest, a routine roentgen survey for tuberculosis, or an employment film, has divulged a suspicious appearing lesion in the lung fields. Some of the patients do have symptoms referable to the chest which are not of sufficient magnitude to be alarming to the patient. Others may be entirely asymptomatic. As more and more of these routine roentgen examinations are made, the incidence of early diagnosis of carcinomas will increase. It is disappointing, however, when an occasional patient with carcinoma of the lung so detected is followed unduly long because a definite diagnosis of malignancy was not established earlier.

Any lesion of the lung field is a dangerous lesion. Until reliable cancer detection tests are developed, the limitations in making a definite diagnosis on any given early lesion must be fully realized. There are methods which aid us in

our attempt at a definite diagnosis of malignancy. If these are exhausted and the diagnosis still is in doubt, it is far better to perform an exploratory thoracotomy with resection of the lesion than to merely watch it grow.

DIAGNOSTIC PROCEDURES

The early diagnosis of bronchogenic carcinoma first depends upon the realization of the possible significance of the presenting chest symptoms. Initially, there may be no symptoms or perhaps only a mild irritative cough, slight hemoptysis, or what might be described as a "chest cold." The physical examination of the chest may or may not show any abnormality. In spite of the paucity of presenting symptoms and the absence of physical findings, a roentgen examination of the chest should be obtained. This may or may not be diagnostic of malignancy. The tumor must attain a certain size before it will cast a roentgen shadow or give evidence of other secondary manifestations.

If the symptoms persist even though the first roentgen examination is negative a second roentgenogram should be obtained within a month's time. The patient should also be examined with the bronchoscope. One should not be led into a false sense of security because one roentgenogram of the chest failed to show a significant lesion. A number of patients have been seen with advanced bronchogenic carcinoma who have had normal appearing x-rays of their chest two to four months previously. The presence or persistence of an irritative cough or hemoptysis is in itself justification for a bronchoscopic examination even though the roentgenogram of the chest is either essentially normal or not definitely diagnostic.

Sixty to seventy per cent of bronchogenic carcinomas arise in the main bronchi. These usually can be visualized bronchoscopically and a biopsy performed. Those tumors arising in the periphery of the lung or in the upper lobe bronchi may be beyond bronchoscopic vision. A negative bronchoscopic examination does not eliminate malignancy as a possibility. Visualization of the bronchial tree by the instillation of iodized oil is rarely of any value in the diagnosis of carcinoma, may be misleading, and its reaction may make the interpretation of subsequent roentgen examinations difficult unless water soluble contrast media is used.

It is needless to mention the importance of lateral and oblique roentgenograms. Inspiratory-expiratory views are important in demonstrating the presence of obstructive emphysema in patients with a wheeze. Laminograms are frequently of value in demonstrating bronchial obstruction and often provide considerable detail of the tumor mass. Such an examination is of particular value in upper lobe lesions where the tumor cannot be visualized bronchoscopically.

The careful cytological examination of bron-

chial secretions and bronchial washings for tumor cells by the Papanicolaou technique is becoming increasingly valuable. Such examinations have increased the incidence of positive preoperative diagnoses considerably in those clinics extensively employing this procedure. This examination may be without value, however, in the early dry peripheral type of tumor. In such patients bronchial irrigation with 3 to 5 cubic centimeters of saline solution may yield sufficient desquamated tumor cells to be diagnostic. This procedure will become more important as experience is gained in the cytological recognition of cancer and pre-cancer cells. The development of a reliable serologic test for malignancy will be a noteworthy advance. In any event, the problem rests with the physician first seeing the patient. He must be alert as to the potentialities of the malignancy of the growth and request such examinations.

Aspiration biopsy of peripheral lesions should not be practiced. The aspirated material frequently leads to inaccurate opinions, for the specimen obtained is usually insufficient in amount to allow an accurate diagnosis. It may represent only the inflammatory elements of the lesion. Pleural infection and the transplantation of malignant cells along the course of the needle tract may result. Occasionally a diagnostic pneumothorax may delineate a mass in the lung from a possible one in the chest wall, mediastinum, or diaphragm.

Over 50 per cent of patients with bronchogenic carcinoma have what is felt to be either a respiratory infection or pneumonia during the early period of their illness. The importance of the "check-up" x-ray examination in pneumonic lesions in spite of clinical improvement should be emphasized. If every case of bronchopneumonia were followed to complete resolution by repeated roentgen examinations carcinomas would be suspected earlier in those that did not clear.

If the pneumonic lesion persists for longer than several weeks, malignancy or some other complication should be suspected. Occasionally there is such a dramatic clinical and roentgen improvement of a pneumonic lesion with the use of antibiotics that one feels relatively certain the possibility of a carcinoma can be eliminated. However, if any abnormality whatsoever persists in the roentgenogram one should still suspect malignancy. The significance of the "persisting lesion" or the "failure of complete resolution" should be appreciated as possible warning signals of an early carcinoma. Too frequently valuable time is lost while a carcinoma is masquerading under the diagnosis of "virus pneumonia," "unresolved pneumonia," "chronic pneumonitis," or "residual pleural thickening."

If there is reasonable suspicion that a carcinoma exists after all the diagnostic and therapeutic aids have been exhausted, bacteriological studies have eliminated tuberculosis, and the

response to an intensive course of antibiotics in the infectious group has not been complete then an immediate exploratory thoracotomy is mandatory without further delay. Such a period of diagnosis and observation should not require over several weeks to perform. Any delay may make the difference between an operable lesion and one that is inoperable. The diagnosis of carcinoma of the lung depends upon the correlation and interpretation of the clinical, roentgen, bronchoscopic, and laboratory findings.

The early manifestations of bronchogenic carcinoma follow:

THE NEGATIVE CHEST

The roentgen shadow cast by a neoplasm consists mainly of the secondary manifestations of the tumor; that is, the atelectasis, infection, and edema comprise a large portion of the shadows seen. There is a period during the early growth of the bronchial neoplasm before these changes become apparent in the roentgenogram. During the early phase the only clue may be a persistent cough, wheeze, or hemoptysis. These are indications for a bronchoscopic examination even though the roentgenograms may be normal.

OBSTRUCTIVE EMPHYSEMA

As the bronchogenic carcinoma grows it first causes irritation and then partial bronchial obstruction. This may result in obstructive emphysema of a pulmonary segment, lobe, or entire lung. The bronchi dilate in inspiration. This allows the inspired air to pass by a partially occluding tumor mass. In expiration when the bronchi are smaller the egress of air is hampered and obstructive emphysema may result distal to a partially occluding mass. Symptomatically this partial bronchial occlusion evidences itself in a wheeze which not uncommonly simulates asthma.

Patients previously free of allergic phenomena who develop a wheeze or asthmatoïd type of breathing associated with dyspnea should be suspected of having a bronchial tumor. Where unilateral wheezing is present one should be especially suspicious of neoplasm.

ATELECTASIS

With further growth of the tumor bronchial occlusion results. Varying degrees of infection as well as atelectasis may now be present. The distribution of the atelectasis may be either lobular, lobar, or involve the entire lung. Atelectasis resulting from occlusion of the larger bronchi is usually readily recognized. However, segmental atelectasis may be less suggestive of malignancy. If the lesion causing bronchial occlusion arises in an upper lobe bronchus it may be just beyond bronchoscopic vision. Bronchoscopic visualization of the tumor may be even more difficult if atelectasis is present with further retraction of this lobe.

The use of the right angle telescope increases the bronchoscopic visual range. Many of these

upper lobe tumors can now be visualized but not admit of a biopsy. A negative bronchoscopic examination does not rule out the presence of malignancy. Laminographic and cytological examinations may well confirm the presence of a carcinoma. If the presence of atelectasis, regardless of the degree or extent, cannot otherwise be explained then an exploratory thoracotomy should be performed.

BRONCHOPNEUMONIA

It is the lobular type of atelectasis and infection that most frequently passes under the diagnosis of bronchopneumonia or virus pneumonia. The clinical and physical findings of bronchopneumonia are quite characteristic but the stethoscope cannot determine the etiology. It is also virtually impossible to differentiate roentgenologically between a pneumonitis due to infection and that secondary to malignancy on a single roentgen examination. Not only should a roentgen examination of the chest be made but it should be repeated until all evidences of the bronchopneumonia have cleared. If the patient is discharged from the hospital on the basis of clinical improvement alone, a carcinoma may well be overlooked. Uncomplicated bronchopneumonia will clear in the expected period of time. Unresolved pneumonia not infrequently means that some other condition is present, such as tuberculosis, bronchiectasis, suppuration, or bronchial occlusion possibly due to a tumor.

If following a course of the antibiotics, a roentgen shadow persists in spite of clinical improvement, active steps should be taken to determine the reason for the failure of complete resolution rather than adopting a "wait and see" policy. If diagnostic steps fail to identify the lesion, an exploratory thoracotomy should be performed. The operative morbidity and mortality is today practically negligible for an exploratory thoracotomy. Consequently, one should not hesitate to recommend this course of action. Lesions would be operated upon earlier in a less advanced stage. This policy might also lend itself to the conservation of more pulmonary tissue in certain instances. One might raise the question as to the fate of the non-malignant lesions encountered at the time of the exploration. Their operative correction is still the procedure of choice if they have failed to improve on conservative measures, or are causing recurrent trouble.

UPPER LOBE LESIONS SIMULATING TUBERCULOSIS

About 30 per cent of bronchogenic carcinomas arise in the upper lobe bronchi. The insidious onset of a cough, hemoptysis, low-grade fever, loss of weight, ease of fatigue, and occasionally night sweats in patients with bronchogenic carcinoma as well as in patients with tuberculosis makes the differentiation between the two diseases even more difficult if the malignancy arises in the upper lobe. Unfortunately, bronchoscopic

examination may not provide a positive tissue diagnosis if the lesion is more than one and one-half centimeters beyond the upper lobe bronchial orifices. If tuberculosis cannot be demonstrated by repeated examinations of the sputum and gastric washings, or if the lesion appears atypical in patients of an older age group, malignancy should be suspected. Examination of the sputum or bronchial washings for malignant cells is most important in these patients.

THE ENLARGED HILAR SHADOW

Minimal enlargement of the hilar shadow may either escape detection or be questionable. The asymmetry of the two sides may give some indication of an abnormal process. The significance of minimal enlargement may be questioned and valuable time lost before another roentgen examination is obtained or bronchoscopic examination requested. The enlarged hilar shadow may represent inflammatory or neoplastic lymph nodes, bronchial, vascular, or cystic diseases, or it may be due to inflammation or neoplasm of the underlying lung. If limited to one side it is less likely to be secondary to Hodgkin's disease, lymphoblastoma, or Boeck's sarcoid, but this is not always true.

If a suspicious tumor is present and a definite diagnosis cannot be made it is unwise to lose valuable time with preliminary irradiation in the hopes that it may be a lymphoblastoma or Hodgkin's disease. Certainly, if a positive diagnosis cannot be obtained from a peripheral lymph node biopsy, the patient should be at least examined with the bronchoscope, and even explored in an attempt to obtain a definite diagnosis before subjecting him to a course of irradiation. It is better to explore all questionable tumors that cannot be definitely diagnosed, than to allow them to become inoperable while pursuing other forms of therapy. If found inoperable, a biopsy can be obtained and roentgen therapy more intelligently administered.

INTERLOBAR EFFUSION

Neoplasms in the middle lobe or dorsal lobe bronchial area occasionally cast a fusiform roentgen shadow in the infra-hilar region easily mistaken for and difficult to differentiate from an interlobar effusion. Such effusions are relatively rare and not as frequent as might be suggested radiographically. This is particularly so when they are unaccompanied by other evidences of pleural disease. Atelectasis by tumors frequently cause identical shadows and occasionally both conditions may exist.

PERIPHERAL TUMORS

Approximately 30 per cent of bronchogenic carcinomas arise in the periphery of the lung. These are usually adenocarcinomas. They are a more malignant tumor than the more centrally located squamous cell carcinoma. These car-

cinomas frequently have a latent stage during which time they are asymptomatic. Others have an insidious onset of an irritative cough, dull pain in the chest, pleural pain, and occasional hemoptysis. They frequently simulate tuberculosis, tuberculomas, cysts, or metastases. They infiltrate the pleura early and often cause pleural effusions. It is impossible to view these tumors bronchoscopically because of their peripheral location. Bronchoscopic examination is still indicated because not uncommonly the parenchymal lesion may be a secondary manifestation of a more centrally located tumor.

Sputum studies and examination of bronchial washings for malignant cells is most valuable in obtaining a diagnosis. If tuberculosis cannot be demonstrated, and such lesions fail to respond completely to an extensive course of antibiotics, immediate exploration is indicated.

THE PULMONARY ABSCESS

Ten to 15 per cent of bronchogenic carcinomas become necrotic and cavitate. If the bronchus is occluded the roentgen shadow may appear as a solid mass or there may be evidence of a fluid level if the contents can be evacuated. Occasionally the abscess is a secondary manifestation in an area of pneumonitis distal to a bronchus occluded by tumor. Occasionally it is possible to demonstrate a ring shadow or cavity into which a mass projects. The present-day treatment of such cavities is pulmonary resection rather than drainage. Consequently, such lesions are not likely to go untreated. Because of the frequency with which pulmonary abscesses are found to be either primary or secondary to bronchogenic carcinoma, one should consider the possibility of malignancy to be present in all atypical abscesses in the older age group and should resort to pulmonary resection rather than to drainage in doubtful cases.

AORTIC ANEURYSM

An enlarged hilar shadow over the aortic knob in a patient with a history of syphilis and a positive reaction to Kahn or Wassermann test may, of course, suggest the presence of an aortic aneurysm. If the diagnosis is questionable, angiograms can be performed, in addition to the other diagnostic studies.

BRONCHIECTASIS AND PULMONARY CYSTS

Bronchiectasis and pulmonary cysts are generally considered benign conditions. However, both of these conditions are potentially dangerous because of the chronic ulceration, infection, and associated squamous metaplasia. There have been seven such patients observed by the author, in whom malignancy developed in previous areas of bronchiectasis or bronchogenic cysts. Because of this potential hazard, as well as those of infection and hemorrhage, surgical extirpation of such cysts is indicated, par-

ticularly so if there is evidence of recent change. The same is perhaps true of patients with bronchiectasis.

SUMMARY

The present status of carcinoma of the lung is discussed. As a result of the educational efforts in behalf of this disease patients are being seen in an earlier phase of their disease as evidenced by the resectability rate of 32 per cent today as compared to 7.5 per cent 10 years ago. The curability of patients operated upon in the early phase of their disease is evidenced by the 70 per cent survival rate following therapeutic resections. The early signs and symptoms of carcinoma of the lung are presented. Continued efforts should be made for the early detection of bronchogenic carcinoma.

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Franklin County Pelvic Cancer Delay Committee Report

By JOHN H. HOLZAEFFEL, M. D.
Columbus, Ohio, Chairman

The Franklin County Pelvic Cancer Delay Committee met Wednesday, December 21, 1955, at 12 o'clock noon. One case was discussed.

Case 11: This patient is a 64 year old white female. At the age of 24 she had a subtotal hysterectomy. The past history is somewhat hard to get from the patient. She states that she began to have vaginal bleeding in September 1955. She reported for examination and treatment and was found to have a far advanced squamous cell carcinoma of the cervical stump with extension down the anterior wall of the vagina to within 1 centimeter of the introitus. Because of the extensiveness of the disease, it was elected to proceed with external therapy first.

Comments: *Dr. Harry E. Ezell:* There is an ever-present danger of carcinoma in any organ which is not completely removed 40 years prior to present onset of disease.

Patient had approximately six weeks delay on the part of the physician.

NEW MEETING PLACE

Beginning in January 1956 the Pelvic Cancer Delay Committee met for luncheon at the Columbus Health Center on the third Wednesday at 12 o'clock noon. These meetings are scheduled to be held on the third Wednesday of each month at the Columbus Health Center and Dr. Goodloe has assured us that we will have luncheon available. The meetings last one hour, beginning promptly at 12:00 noon and ending at 1:00 p.m. It is hoped that all of the hospitals in Columbus will participate.

Some Urological Aspects of Carcinoma of the Cervix: A Review of Recent Literature

JOHN C. BUCKINGHAM, M. D., and JACK N. TAYLOR, M. D.

THAT untreated cervical carcinoma affects organs of the urinary system has long been known. Modern forms of treatment of this disease have occasioned additional hazard to the urinary tract. The importance of these considerations is further emphasized by knowing that today cervical cancer represents about one-fifth of all malignant disease in the female. With this in mind we felt a review of this subject might help us to face this problem more intelligently in our hospital.

From autopsy studies it has been learned that the urinary tract is involved in the majority of cases of carcinoma of the cervix. De Alvarez¹ reported that in 40 per cent of his cervical cancer cases studied at autopsy, death occurred from urinary tract invasion and/or obstruction secondary to this lesion. In 166 postmortem studies Behney²⁷ found 65 per cent incidence of hydro-ureter attributable to cervical cancer. Recently Dearing⁷ listed an incidence of 74.6 per cent ureteral obstruction in a similar necropsy study of 71 cases. Bladder invasion by cervical carcinoma as found at autopsy varied in incidence as reported by different observers, viz: 45 per cent (De Alvarez)¹; 69 per cent (Graves)⁵; 22 per cent (Colby)⁶; and 50 per cent (Herger and Schreiner).⁴

Clinical urological investigation of cervical cancer patients has produced statistical data which varies with the number and type of patients selected. In general, however, this clinical data agrees closely with the findings in the necropsy studies mentioned above. Roentgenological evidence of unilateral or bilateral hydro-ureter and hydronephrosis was found in 48 per cent of patients studied by Herger and Schreiner,⁴ in 35.1 per cent of the series reported by Colby,⁶ and in 35.7 per cent of cases reviewed by Jaffe, Meigs, et al.¹¹ Diehl and Hundley,¹⁰ Aldridge and Mason,¹² and Dearing⁷ observed this change in 27 per cent, 34 per cent, and 29.6 per

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cent, respectively, of their carcinoma patients studied with excretion urography. As an example of this type of data, a summary of Dearing's series is presented in table 1.

This data indicates that a higher percentage of abnormal pyelograms is found in the more advanced clinical stages of cervical cancer.

Early cancer in clinical stages I and II shows urological involvement in 11 per cent and 25 per cent of the cases studied. This latter information means that abnormal pyelograms can be found in patients who show no clinical evidence of parametrial spread of cancer, and that the clinical impression of the extent of the disease needs revision in such cases.

A study of table 1 reveals that for each clinical stage of cervical cancer the finding of abnormal pyelograms signals a poorer prognosis. The survival rate one year following cancer therapy in those patients who had abnormal pyelograms initially was only 29 per cent as compared to 68 per cent survival in those with normal pyelograms.

Aldridge and Mason¹² in a similar study of 333 patients four years after cancer treatment listed

Submitted March 10, 1955.

TABLE 1—(from Dearing⁷). EXCRETORY UROGRAMS IN PATIENTS WITH CARCINOMA OF THE CERVIX.

Stage	Total Cases	Abnormal Pyelograms	Stage	Total Cases	Survival 1 year after treatment			
					75 Abnormal Pyelograms		189 Normal Pyelograms	
					Dead	Alive	Dead	Alive
I	70 (21%)	8 (11%)	I	70	4	4	14	48
II	180 (55%)	44 (25%)	II	149	26	13	34	76
III	41 (13%)	21 (51%)	III	33	17	4	8	4
IV	36 (11%)	24 (67%)	IV	12	6	1	4	1
Total	327 (100%)	97 (30%)	Total	264	53	22 (29%)	60	129 (68%)

a gross survival rate of only 16 per cent in the abnormal-pyelogram group compared to 62 per cent for those with normal pyelograms. Aldridge and Mason also observe that their incidence of 34 per cent ureteral obstruction determined pyelographically compares closely with the autopsy incidence of 40 per cent found by De Alvarez¹ in studying this same group of patients. This agreement is interpreted to mean that ureteral involvement is due to carcinoma alone, rather than to the effects of irradiation or to other causes.

The clinical study of bladder abnormalities in cervical carcinoma patients was carried out by several authors. The reported incidence of bladder abnormalities was 21 per cent by Colby,⁷ 18 per cent by Diehl and Hundley,¹⁰ and 20 per cent by Dearing.⁷

SPECIFIC UROLOGICAL COMPLICATIONS OF CANCER OF THE CERVIX

URETHRAL COMPLICATIONS:

Neoplastic invasion of the urethra occurs with unknown frequency. Beech¹³ reported this complication as causing complete urinary retention in a patient with far advanced cervical carcinoma. Permanent suprapubic cystostomy was performed.

BLADDER COMPLICATIONS:

The etiology of bladder complications includes (1) untreated tumor, (2) acute or remote post-irradiation reactions, and (3) pelvic surgery.

UNTREATED TUMOR

Bladder involvement by uncontrolled tumor is known to lead to vesicovaginal fistula in many cases surviving long enough. Graves, et al.,⁵ listed 12.9 per cent of 425 cases of cancer of the cervix as having vesicovaginal fistula. From this study these observers feel that one can predict an average survival time of five months when a fistula develops in the presence of active cancer. Behney²⁷ found vesicovaginal fistula in 22.3 per cent of 166 autopsy cases of advanced carcinoma of the cervix. No treatment had ever been given in 86 of these cases and 25.6 per cent of them showed fistulae. The incidence of fistula formation in 80 treated cases of this series was found to be 18.7 per cent.

Warren¹⁴ found that 35.3 per cent of his post-mortem cervical cancer cases had vesicovaginal fistulae and he also concluded from his study that there was no significant difference in incidence of fistula between treated and untreated cases.

Correction of these fistulae is usually not considered because the tissue changes secondary to irradiation make healing improbable or because of the poor prognosis in the presence of uncontrolled cancer.

It is true that bladder symptoms commonly accompany vesical invasion by cervical cancer; however, in some cases with such involvement, there may be no symptoms referable to urination.

It is also well known that bladder invasion by cervical carcinoma can occur prior to parametrial extension. Dearing⁷ discovered that 51 per cent of patients having abnormal cystoscopic findings and normal pyelograms were dead in the first year after initial study. This emphasizes, then, that no patient with diagnosed cervical carcinoma can be evaluated adequately in the absence of cystoscopy.

The earliest cystoscopic evidence of cervical tumor involving the bladder is elevation of the bladder floor due to extrinsic pressure. Further bladder wall invasion results in edema of the trigone, localized areas of increased vascularity, and, ultimately, in ulceration and visible mucosal infiltration. In these later stages biopsy may reveal the diagnosis. It must be pointed out, however, that not infrequently it is difficult to differentiate histologically late bladder irradiation changes, primary bladder tumor, and invading cancer of the cervix.

Treatment of bladder invasion by tumor was not discussed in the papers reviewed. It may be added, however, that treatment in these cases must be planned after careful evaluation of the individual case. Interstitial irradiation or radical pelvic exenteration may be considered.

IRRADIATION REACTIONS

Two types of irradiation bladder reactions are distinguished—delayed and acute. The delayed variety is more important because of its much greater incidence and because of the deceptive time lag between irradiation and onset of symptoms.

Watson, et al.,¹⁵ studied 5,990 patients receiving pelvic irradiation for various reasons and found that 2.74 per cent of them had irradiation bladder reactions. A similar study by Dean and Slaughter¹⁷ of 3,041 patients showed that 2.48 per cent of them had similar involvement. It is more important to note that in Watson's series 98 per cent of the reactions were of the delayed type. Generally it is recognized that such reactions may occur as long as 10 years and rarely less than one year after irradiation therapy. The average time elapsed after irradiation and the onset of bladder symptoms is given by Dean and Slaughter^{16, 17} as 2.5 years and by Graves, et al.,²⁰ as 2.25 years.

Radium irradiation preceded virtually every delayed bladder reaction observed. The extent of bladder damage and the promptness of symptom onset depended directly on the amount of irradiation received. Fistula formation may represent the end stage of severe irradiation reaction. Morton and Kerner¹⁸ reported 16 fistulae in 621 irradiated patients or an incidence of 2.5 per cent.

Prominent symptoms of delayed bladder injury are increased urinary frequency, hematuria, and dysuria. According to Dean and Slaughter,¹⁶

over 80 per cent of these patients experience dysuria, while 45 per cent have painless hematuria.

The cystoscopic appearance of telangiectasis, bullous edema, or ragged ulcerations covered with necrotic slough or calcific encrustations located in the midline on the posterior aspect of the bladder suggests the diagnosis. A careful biopsy may prove conclusive, but the histological picture can be equivocal, as previously mentioned.

In treating these lesions supportive care and chemotherapy are indicated. In the experience of Dean and Slaughter¹⁶ bladder symptoms subside after the eradication of urinary infection, even in the presence of areas of bladder ulceration. Watson, Herger, and Sauer¹⁵ advocate cautious coagulation of bleeding points and removal of necrotic slough by rongeur when necessary. When calcific deposits occur in the bladder continuous bladder irrigation with solution G and, when feasible, mechanical removal are of definite value.

Prognosis for healing in late bladder reactions is favorable except when damage is very extensive after a slough. Under treatment these ulcerations may heal in 4 to 18 months, depending on extent and severity.

Acute type bladder injury follows external irradiation almost exclusively. This condition begins with bladder irritative symptoms 24 to 48 hours following external irradiation. Diffuse hyperemia of bladder mucosa is seen on cystoscopy. Symptomatic treatment of this type of bladder injury will suffice, as this difficulty usually is self-limited and seldom persists longer than two weeks.

Dean¹⁷ lists also a bladder reaction occurring in some cases an average of 28 days after irradiation. Mild irritative bladder symptoms accompany a cystoscopic picture of "secondary erythema."

PELVIC SURGERY

In a recent article Beech¹³ lists a 17 per cent incidence of bladder injury complicating Wertheim hysterectomy for cervical carcinoma. He also states that in 7 per cent of these patients vesicovaginal fistulae occur. Holloway¹⁹ and others agree that simple suture of the bladder at the time of injury along with catheter decompression afterwards results most often in little or no increase in morbidity. Bladder injury not recognized until the postoperative period usually causes increased morbidity due to extravasation of urine.

URETERAL COMPLICATIONS:

The incidence of ureteral complications associated with carcinoma of the cervix and its treatment by irradiation has previously been listed. The autopsy studies cited reveal the extent to which ureters have been involved by cancer in each series. Clinical studies showing upper urinary tract obstruction are thought possibly to include cases where this is secondary to radia-

tion scarring or necrosis. The extent of this factor, however, is not known in most series. Causes of ureteral damage must include (1) direct extension and invasion by cancer, (2) extrinsic ureteral pressure due to metastatic lymph node involvement, (3) radiation scarring or necrosis, and (4) injury—a complication of radical surgery.

Exact mechanisms of ureteral involvement by cancer are indicated by histological study in a necropsy series of 71 cases reported by Dearing.⁷ In 44 (74.5 per cent) of these ureteral obstruction was found. Tumor in the broad ligament caused the obstruction in 13 cases, while in 10 more involved lymph nodes alone were responsible. Local extension other than into the broad ligament, remote metastases (one to lymph nodes), and obstruction by lymph nodes on one side and broad ligament tumor on the opposite side were found to exist in two cases each. Obstruction caused by permeation of periureteral lymphatics occurred four times. Gross pelvic involvement by cancer was present in six cases. Postoperative infection was shown to be responsible in one case. Lastly, in this same autopsy series four cases of ureteral obstruction due definitely to radium necrosis were found.

Radical pelvic surgery for carcinoma of the cervix, using the Wertheim hysterectomy or some modification thereof, results in an incidence of 7 to 10 per cent ureteral injury in the hands of experienced surgeons. Meigs² reports an incidence of 7 per cent ureterovaginal fistulae in a series of cases of carcinoma of the cervix treated surgically.

CLINICAL DIAGNOSIS

The clinical diagnosis of these ureteral complications, secondary to the foregoing causes, can be determined by complete urological investigation. Usually, however, indirect measures are inadequate for the *exact* differentiation of the first three categories. The cause may be more easily presupposed in an instance where ureteral involvement, not present preoperatively, occurs immediately following surgery.

Routine use of excretory urography has repeatedly demonstrated ureteral obstruction in cervical cancer patients who have no symptoms referable to the urinary tract and/or who show no clinical evidence of extension or recurrence of their cancer. Not infrequently bilateral lower ureteral obstruction is noted. In those cases in which unilateral obstruction is presumed due to cancer, the potential involvement of the remaining side must always be considered.

TREATMENT PROCEDURES

Of the methods of treatment available for such ureteral obstruction, the simplest is ureteral dilation; but this has been proved to be of little or no value. Urinary diversion by cutaneous ureterostomy is frequently technically impossible

because of severe postirradiation devitalization of pelvic tissue, including the lower ureters. For this same reason uretero-intestinal anastomosis is hazardous. Therefore, nephrostomy drainage is considered the procedure of choice for the relief of such obstructive uropathy by most authors. It should be hastily added that such treatment is frequently omitted in the belief that a uremic death is the more pleasant alternative to the terminal carcinoma patient with a short life expectancy.

An argument in favor of urinary diversion is the finding by Dearing⁷ that in four cases of treated cervical carcinoma death resulted from radiation necrosis of the ureters.

The proper method for the relief of ureteral obstruction in a cervical cancer patient can be chosen only after careful evaluation of the status of the urinary tract, the extent and activity of the pelvic cancer, and the general condition and life expectancy of the patient.

DISCUSSION

This review indicates to us that once the diagnosis of carcinoma of the cervix is established clinical pretreatment evaluation must include cystoscopy and assay of the status of the upper urinary tract by excretion or retrograde urography. This information, coupled with the clinical findings of the gynecologist, is essential to estimate more accurately the extent of the cervical carcinoma.

In addition, pretreatment urological investigation has been shown to be of value in estimating the prognosis of the patient. Such information also is valuable as a point of reference for similar post-treatment urological studies.

The presence of normal pyelograms in a case of proved post-treatment recurrence of cervical cancer (e. g. bladder invasion) might argue for localized interstitial irradiation or radical pelvic surgery.

Even though there is evidence that irradiation necrosis of ureters causes death in a few cases of treated cervical cancer, no sure method exists for distinguishing these obstructions from neoplastic obstructive uropathy.

Careful clinical evaluation of the patient in conjunction with a study of the progress of the associated obstructive uropathy may help the responsible physician to decide whether or not urinary diversion is the procedure of choice to relieve impending renal failure in the individual case.

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The Question of Effort and Acute Coronary Insufficiency

The relationship of effort to the development of acute coronary insufficiency and coronary thrombosis is highly controversial. The evidence that intimal haemorrhage is due to effort is lacking. The clinical evidence supports the view that ordinary effort is not a factor, but that strenuous effort may be, in a small group of cases. My own opinion is that ordinary effort is certainly not a precipitating factor, but may in fact be a preventive measure, in that the heart is much like any other muscle in the body, and is healthier if exercised.

Moderate exercise, in the presence of coronary sclerosis without symptoms, should stimulate the development of anastomotic circulation. One cannot deny, however, that violent and undue effort in the presence of marked coronary atherosclerosis, may precipitate acute coronary insufficiency. —John D. Hamilton, M. D., Toronto, Canada: *J. Arkansas Med. Soc.*, 52:1, 1955.

The Diagnosis of Pheochromocytoma in Children

A Pediatric Review

LOUIS SCHWAB, M. D.

DETAILED knowledge of rare syndromes often is only of academic value. In the case of a potentially fatal, but curable disorder, however, awareness of the details of the syndrome is mandatory, regardless of how rare the condition may be. A classic case in point is pheochromocytoma, the rare epinephrine and norepinephrine producing tumor occurring most commonly in or near the adrenal glands.

In 1947 in the first major paper calling attention to the existence of this tumor in children, Snyder and Vick⁹ were able to list a total of only six cases reported up to that time. In the intervening eight years an additional 28 cases have been reported, bringing the total to 34 cases.^{1, 5, 7} However, nine of these additional cases have been reported in the past two years, indicating an increasing awareness of this syndrome in recent years. In spite of the rarity of the tumor the importance of its recognition warrants a review of its diagnostic features in childhood.

THE CLINICAL PICTURE

In the early clinical descriptions of the hypertensive syndrome produced by the tumor in adults the intermittency of the hypertension was emphasized. This has come to be regarded as a classic feature of the tumor in spite of the fact that it has been emphasized repeatedly that in the adult sustained hypertension is seen in the great majority of cases. In children this is true to an even greater extent, Daeschner et al.² noting intermittent or paroxysmal hypertension in only two of 18 reported cases. Therefore, any hypertension in children, whether paroxysmal or not, should be regarded as possibly due to pheochromocytoma until proven otherwise.

Other than this quantitative difference with respect to the type of hypertension seen, the clinical picture in the child is essentially the same as that in the adult. Four outstanding symptoms should be emphasized: (1) severe, intermittent headaches, which characteristically increase in frequency and severity over a period of months or years; (2) excessive sweating, including drenching night sweats; (3) anxiety, nervousness and irritability; and (4) weight loss, often of marked degree, or poor weight gain. All are directly attributable to hypertension. In addition to these a wide variety of less common symptoms have been reported: weakness, precordial pain, visual disturbances, polyuria, polydipsia, polyphagia, constipation, epistaxis, convulsions and encephalopathy.

The Author

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The physical findings are all secondary to the hypertension, which may be extremely marked even in young children, and in general are those seen in hypertension from any cause. The pulse is often rapid and there may be cardiac enlargement and electrocardiographic evidence of left ventricular hypertrophy. Retinopathy, with papilledema, hemorrhage and arterial narrowing is common. Urinalysis frequently reveals a mild albuminuria.

In addition to these predictable findings three other somewhat bizarre signs commonly occur. These are a variety of peripheral vasomotor changes (discolorations of the skin, cold, clammy hands and feet, etc.), mildly elevated fasting blood sugars and mildly elevated basal metabolic rates.

LABORATORY DIAGNOSIS

If the clinical picture raises the suspicion of pheochromocytoma, the diagnosis can be confirmed with great accuracy. The diagnostic procedures available can be classified in three categories: provocative tests, suppressive tests and definitive tests. The simplest provocative test is deep massage of the flanks, which, in the presence of a pheochromocytoma in this region, may lead to a rapid release of norepinephrine and epinephrine from the tumor with a subsequent increase in blood pressure.

A more drastic maneuver is the intravenous injection of histamine, which also leads to an elevation of blood pressure in the presence of pheochromocytoma, presumably as a compensatory response to the initial hypotension produced by histamine.¹⁰ Both tests are useful only when the patient is in a normotensive state and should not be attempted as diagnostic procedures in the face of existing hypertension. Because of the rarity of paroxysmal hypertension in children, these tests will seldom be used in this age group.

The suppressive tests all depend on a neutralization of the pressor effect of norepinephrine and epinephrine by a number of pharmacologic agents, with a subsequent temporary lowering of blood pressure. The principal agents which

Submitted December 20, 1955.

have been used for this purpose are benzodioxane, dibenamine and regitine®. The use of benzodioxane leads to a variety of unpleasant side effects and, occasionally, severe compensatory hypertension.¹⁰ Dibenamine may lead to marked hypotension and its action is prolonged. Regitine® has none of these disadvantages and has the additional advantage of being equally effective whether administered intravenously, intramuscularly or orally in appropriate doses.² Regitine® is, therefore, the diagnostic drug of choice.

The adult test dose is 5 mgm. given intravenously; test doses in children are reduced proportionately to weight. Since both false positive and false negative tests have been reported for all three agents, no single test should be rigidly relied upon, nor the diagnosis considered to be established unequivocally without a positive definitive test.⁴

The definitive tests for pheochromocytoma depend on the actual identification in the urine of abnormal quantities of norepinephrine and epinephrine. In the presence of pheochromocytoma this abnormal excretion persists even during normotensive periods.³ No simple analytic method is available. Moulton and Willoughby⁶ have recently described a relatively short bio-assay procedure which depends on changes in the anesthetized cat's blood pressure following intravenous injection of urine containing abnormal quantities of the catechol amines, norepinephrine and epinephrine. A variety of relatively complicated chemical methods of identification of catechol amines also are available.³

In cases in which a positive regitine® test has been demonstrated and in which a tumor has been located radiographically, the definitive tests are probably superfluous unless the laboratory facilities for the tests are readily available. However, if faced with only a positive regitine® test in a case in which it has been impossible to identify a tumor radiographically, exploratory operation is unwarranted without preliminary efforts to demonstrate abnormal quantities of urinary catechol amines.

DIFFERENTIAL DIAGNOSIS

In the differential diagnosis of pheochromocytoma two conditions should be emphasized: acrodynia and familial dysautonomia. The hypertension, sweating, irritability and vasomotor changes of acrodynia may closely simulate the clinical picture of pheochromocytoma and the distinction between the two conditions may depend entirely on laboratory evaluation. The clinical features of familial dysautonomia and pheochromocytoma are closely similar, but the striking finding of absent lacrimation and the predilection for children of Jewish descent seen in familial dysautonomia may allow a distinction between the two conditions on clinical grounds alone.

The diagnosis of the presence of pheochromo-

cytoma may be far easier than the localization of the tumor, since the latter may occur at one or more of many sites in the retroperitoneal space, the thorax, neck, brain or even the urinary bladder. The adrenal area is the most common position; therefore, the initial procedure to be attempted is careful palpation of the costovertebral angles and flanks. If a tumor is not palpable, deep massage of the flanks may lateralize the tumor by leading to a transient rise in blood pressure. Regitine® should be available during this procedure to control excessive hypertension.

Intravenous pyelograms are indicated in all cases since the presence of a tumor adjacent to the kidney may be revealed by distortion or displacement of the renal pelvis. In the presence of a normal intravenous pyelogram supplementary localizing procedures are perirenal or presacral air insufflations. If these fail to demonstrate the tumor, a lumbar aortogram may be carried out with the introduction of dye into the abdominal aorta at a site above the adrenal arteries, either through a paralumbar needle or through a femoral artery catheter.⁸

Surgical excision of the tumor is indicated in all cases. Because of the rare occurrence of metastases in the malignant form of the tumor and the more common occurrence of multiple tumors, the absence of remaining tumor tissue should be proved postoperatively in every case, either by use of the histamine provocative test or the urinary catechol amine procedures. In the absence of residual tumor tissue the prognosis is excellent.

SUMMARY

Recurrent headache, excessive sweating, irritability and weight loss are the classic symptoms of severe hypertension in childhood. In this age group confirmed hypertension, whether intermittent or sustained, demands the inclusion of pheochromocytoma in the differential diagnosis. Regitine® is the drug of choice in establishing the diagnosis.

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The Psychological Approach to the Patient To Be Anesthetized

RICHARD C. MILLER, M.D.

IN few branches of medicine is the psychological approach more important than in the patient who is to receive an anesthetic. In modern anesthesia as we know it today where great progress is being made in this comparatively new field, it is even more important for the physician to be aware of the possibilities in this field. The older concept of an anesthetic being a necessary evil to surgery with all its horrors and terrible after-effects has faded with the years. I would like to point out the newer concept which emphasizes an understanding of the psychological condition of the patient.

I. THE MEDICAL ANESTHETIST

First we assume he is competent professionally, an artist, a craftsman with technical skill. In addition to that he must be a persuasive personality as well as a physician. Too many doctors think that the title "doctor" endows them with some ethereal powers and magic. Possibly this was true in bygone days, but in these times the word doctor can mean anything from an optometrist to a physiotherapist, even a medium. Hence we must admit that the former magic implied by the title has been lost. We must then restore our prestige so to speak by radiating a professional confidence to each and every patient with whom we deal. How can this be done? The answer is complex, but here are a few hints to the anesthesiologist. It may well apply to most physicians.

What is the first thing a patient notices about a doctor? I would say that it is his *personal appearance*. The physician should be immaculately clean, neatly dressed, and above all he must be able to SMILE. I recall a physician of my acquaintance who was a well trained surgeon and did excellent work, but he did not "look the part." His clothes were shabby and unpressed and he could never smile. It goes without saying this physician was handicapped from the beginning. I have heard patients say "He doesn't look like a doctor." Contrariwise I know many physicians who are mediocre in their professional skill, but who dress well, have excellent manners, a pleasing personality and possess a large and lucrative practice. What I am trying to bring out is that the anesthetist *must* make a good first impression.

II. PRIOR TO OPERATION

The anesthesia really begins when the patient is first seen. The anesthetist should be cordial

The Author

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and some conversation be engaged in concerning the patient's condition. The anesthetist then begins taking an anesthetic history, taking into consideration the patient's previous anesthetic experiences, if any. He also makes a short but accurate estimate of the patient's general physical state and then engages in a frank discussion with the patient as to what is the best anesthesia available for the surgery to be done.

Frequently I say, "Mr. Jones I know you want to have the best and safest anesthetic we have, and were I to have the same operation I would want the same that I am going to advise for you." This statement, said sincerely, bolsters the patient's confidence in you.

During this time you are estimating the patient's general psychic make-up. One must be a good listener. Sometimes the patient will say, "Doctor, my aunt had one of those long needles stuck in her spine and she says she still feels it! Please don't use any needles on me!!!" Then what do you do when in your opinion this patient should be given a spinal anesthetic? I usually ask "How many years ago was your aunt operated upon?" The answer is irrelevant. In any instance my comment is the following:

"Medicine has made much progress lately and in my experience here we ordinarily do not encounter such troubles." I then advise the patient that we are choosing what is *best for him* and that it will not only help him, but also Dr. Smith who is performing the operation. I never mention the word *spinal* because most laymen have a horror of the word. I say "I will do a nerve block." The anesthetist can also point out the advantages of such anesthesia, such as no nausea or vomiting, no long recovery period, being awake and the ability to eat, smoke and talk sooner. Particularly is the latter important to women! If the patient still refuses, then it is best to abandon your first choice and seek another.

Then we see the patient who is deathly afraid

of ether. This is not a pleasant experience I assure you. Many times one can comfort the patient by telling him that we are going to put him to sleep with "a gas like the dentist uses when he pulls a tooth," or words to that effect. This usually relieves a great fear for such a patient. To others we can tell them that we will "give a little medicine in one of your veins and you will fall asleep rapidly, and when it is all over you will awaken back in your bed." The very mention of "back in your bed" signifies to the patient that the whole procedure will be over once and for all.

I personally feel that being honest and frank with a patient pays off in the long run. If the patient detects an attempt to deceive him, you have lost the first round and possibly the whole contest. You have also lost the cooperation of the patient and you will have troubles from that time on. The anesthetist must SELL the anesthesia.

As a final parting phrase it is best to tell the patient something like this: "I will see that you get a capsule to take tonight which will enable you to get a good night's sleep. You will get another in the morning as well as a hypodermic injection which will make you dopey, but that is the way I want you to be. Get a good night's rest and I will see you in the morning." I never tell the patient the time of the operation because this tends to make him apprehensive as the hour approaches. If the patient should ask, I usually say "I'm not sure yet, sometime in the morning; and besides, you will be sleeping anyway."

III. THE DAY OF OPERATION

The floor nurse, or the private nurse if one is so fortunate as to have one, has her very important part to play in this psychological approach. She must radiate confidence in the ability of the surgeon and the anesthetist. She must be pleasant and aware that the anesthesia really begins with the previous night's medication. There should be as little fuss as possible and she should see that the premedication is given in the ordered amount and at the time specified. When the nurse gives the premedication she should say, "Now this will relax you and possibly put you to sleep," or words to that effect. The patient's room should be quiet and shaded prior to the journey to the operating room. Quiet—and a soft voice—sometimes works wonders.

The anesthetist's first contact with the patient on the day of operation is usually in the operating room, or more ideally in the anesthesia room. I then say a cheery good-morning along with a few questions concerning medication, or dentures, etcetera. If the patient is to get a spinal anesthetic I make it very plain that he WILL FEEL NO PAIN. With apologies to the dental profession I often say: "This will be less painful than having a tooth pulled." When ap-

plying the blood pressure cuff, I tell the patient that we keep a close check on the blood pressure and after taking it the first time I usually say, "Your blood pressure was never better in your life"!!

The patient is ordinarily placed in position by a trained assistant. He must be a psychologist too, as often the patient will ask questions. As I prepare the field I usually tell the patient, "I'm putting some antiseptic on your back and it may be a little cold." Most everybody knows what an antiseptic is, but if you say merthiolate he may become frightened. As the wheal is about to be raised my pet expression is, "You may feel a mosquito bite back here." Never say, "I'm going to inject you with a needle."

From this point on if the patient is sufficiently awake I distract his thoughts with other bits of conversation and usually the procedure is over before the patient is aware of it. When this happens, again it bolsters his courage when he finds out how simple it all is. Then I tell him that soon his feet will become warm (they are already warm) and that he will soon become numb up to his ribs. The anesthetist should again reassure the patient that he is FINE.

TEAMWORK HELPS

It has been my experience that most all patients fear the looks of the operating room, the instruments, etc., so I prefer to cover their eyes. A dampened towel is best. Once in the operating room there should be no noise—especially instrument rattles—and certainly no conversation within hearing distance about the proposed operation. Surgeons should keep talk at an absolute minimum.

The most common error now is preparing the field too soon. The good surgeon always asks the anesthetist if the patient is ready to be prepared. If not, the surgeon must wait. Prior to this the anesthetist may desire to test the skin for height of anesthesia with a pin, or perhaps an Allis forceps. If he does, he should grasp the skin while at the very same time ask the patient some distracting question, such as "How much do you weigh?" and note the patient's facial expressions. If he winces, then anesthesia has not set in. One should never prick the skin and ask "Does that *hurt* you?" It fixes hurt or pain in the patient's mind.

During the operative field preparation the alert anesthetist will tell the patient what is going on and that he may feel something cool. He must also be told that he may feel a little pressure such as the doctors hands but he *will not feel any pain*. Just as the surgeon is about to make the incision I again ask the patient some question, such as "Where do you work?" The facial expression will tell the story.

Some patients prefer to talk throughout the operation. If so, the conversation should not disturb the surgeon. The patient's desire is

what he usually gets. I have heard some anesthesiologists saying to a patient, "Do you feel sick?" This should be worded: "How are you getting along?" If he says he feels sick at his stomach, then it is best to tell the patient that you are going to let him breathe a little oxygen and that the nausea will soon pass away. One must remind him that he is NOT being put to sleep unless you are going to use a gas or pentothal® for some reason or another. Especially is this true in the patient who has previously expressed a fear of ether, or of going to sleep.

When the operation is over it is well to announce it to the patient and then remark something such as "You were just fine all the way." Again his confidence is being increased. Once the patient is back in his bed the anesthesiologist should visit him and give him the instructions he wants carried out. Patients really appreciate this visit. It conveys interest in the individual.

Should the patient be given inhalation anesthesia, local or intravenous, the same general principles should be followed. When applying the face piece for inhalation try to prove to the patient that he can breathe easily with it on. This often allays the fear that he will smother. The induction should be carried out in a quiet room and if gas or ether is used you may tell the patient that he may feel a little dizzy but that he will soon be asleep or, as I often say, "You are doing fine, just keep breathing normally."

During the excitement stage do not "fight" the patient. Often they make purposeless movements and patients should be restrained LIGHTLY or else they misinterpret this as struggling with an adversary. Again remember no preparation or touching the patient until the anesthesiologist gives the "go" sign and this is only done with light surgical anesthesia.

IV. THE POSTOPERATIVE PERIOD

All patients operated upon should be seen by the anesthesiologist after the operation. Some physicians see them immediately and again later in the day. I believe this is good practice because a sharp outlook can be maintained for complications, and besides, the patient appreciates the attention.

About the third or fourth postoperative day is a good time to drop in to see the patient and a most opportune time to deftly slip that little white slip of paper for professional services rendered on the night-stand. Many hospitals include the anesthetic fee in the hospital bill but personally I like a private statement because some cases require more attention and one standard fee cannot apply to all. Besides many patients will gladly pay a fee of twenty-five dollars while others will complain of a ten dollar fee. In any event the great majority of patients appreciate your personal interest as well as

your overall services and the bill is usually paid cheerfully.

V. POOR RISK PATIENTS

Just a word or two concerning poor risk patients: Usually the patient is aware that his condition is not good and the relatives know it too. The anesthesiologist must doubly emphasize that he will administer the safest and best anesthetic of which he is capable, and reassure the patient that he will get the proper care and all should go well. I usually tell relatives accurately and sometimes point-blank that the patient's condition is not the best, but that I will do all in my power to give him the best I know how. If the patient dies the relatives have been forewarned.

SUMMARY

The modern anesthesiologist must be a master in the psychological handling of his patient. He must not only be well qualified professionally, but he must "look the part" and act it too. He must be able to smile. Like all master craftsmen nothing must escape his notice and he should capitalize on every opportunity to give his patient his best, safely and painlessly. As in life it is the little things that count most. There is some truth in the words "vocal anesthesia" which is really a psychological tool and when used properly accomplishes much for the comfort of the patient. Modern anesthesia is an art, a craft and a skill. It is a belated blessing to mankind.

Extent and Depth of Retrolental Fibroplasia Problem

The answer to the problem of retrolental fibroplasia at the present time seems to be, first, preventive. I would recommend that, if oxygen therapy is necessary, the oxygen be used from cylinders which contain only 35 per cent oxygen and 65 per cent nitrogen and that oxygen should not be given routinely but only when its use can be justified. Second, I would advise that the parents of the blind infant with retrolental fibroplasia have a complete medical evaluation of the child and the necessary expert guidance for the continuous mental and physical development begun at once.

This is the one disease that began and can be prevented in the short space of half a generation. The wave of maximal incidence has passed.

In the future new cases of blindness from retrolental fibroplasia should be a rarity. From now on the extent and depth of the problem of retrolental fibroplasia depends upon us as physicians.—Arlington C. Krause, M.D., Chicago: *Illinois M. J.*, 108:337, December, 1955.

Indications and Technique of Cerebral Angiography*

CURWOOD R. HUNTER, M. D.

AT the very beginning I would like to say that in my opinion the use of cerebral angiography as a diagnostic agent is still in its infancy. Since its initial use in the living subject by Egas Moniz⁶ in 1927, there has been little basic change in technique or indications. However, time and experience have produced problems attendant to the use of angiography which require investigation and solution.

DEFINITION AND INDICATIONS

Cerebral angiography consists in the radiological demonstration of the cerebral vascular tree following injection of a contrast medium into the carotid or vertebral circulation. Any focal neurological disorder, not obviously a hypertensive vascular rupture or traumatic intrinsic lesion of the brain, is generally regarded as sufficient indication for this study. However, suspicion of two lesions in particular provides the most frequent indication for cerebral angiography. These are the vascular anomalies, such as saccular aneurysms and arteriovenous malformations, and tumors. In the case of vascular anomalies, such conditions are directly visualized (Fig. 1); whereas with tumors, indication of the presence of a space-occupying lesion is noted either by direct visualization of the mass because of increased vascularity or by displace-

*Read before the Section on Neurological Surgery at the Annual Meeting of the Ohio State Medical Association in Columbus, Ohio, April 14, 1954.

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ment of the relatively standard pattern of the vasculature (Fig. 2).

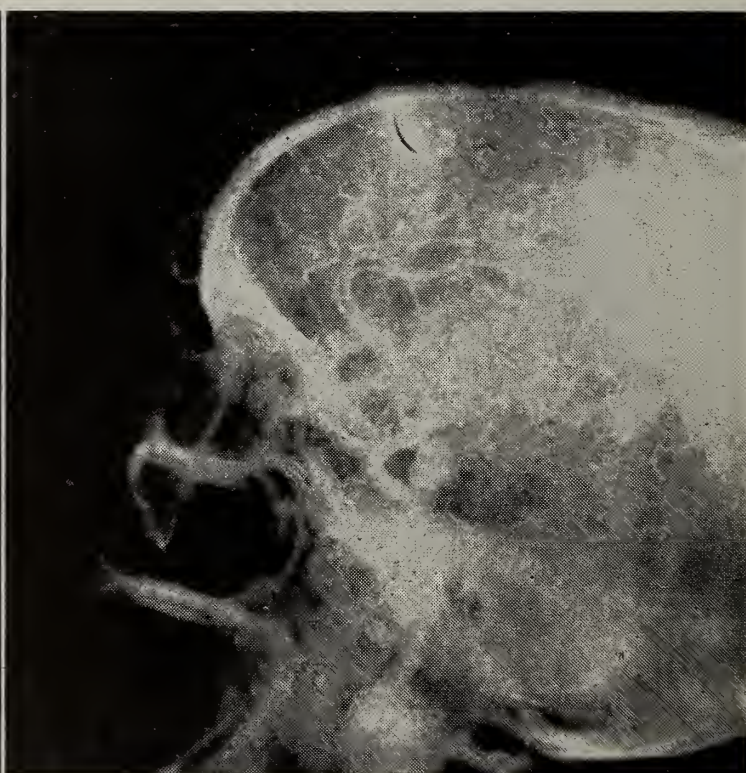
TECHNICAL CONSIDERATIONS

Cerebral angiography is accomplished by one of two techniques: the open, or direct method, and the percutaneous, or indirect method. In the first, the common carotid artery and its bifurcation into the internal and external carotid arteries is visualized through an incision in the neck, transverse or vertical, centered over the anterior border of the sternocleidomastoid muscle at a point just below the transverse level of the thyroid cartilage; then the radio-opaque medium is injected directly into the lumen of the common carotid artery with the stream directed into the current of blood destined for the internal carotid artery.

In the percutaneous or indirect method, a needle is directly introduced through the skin

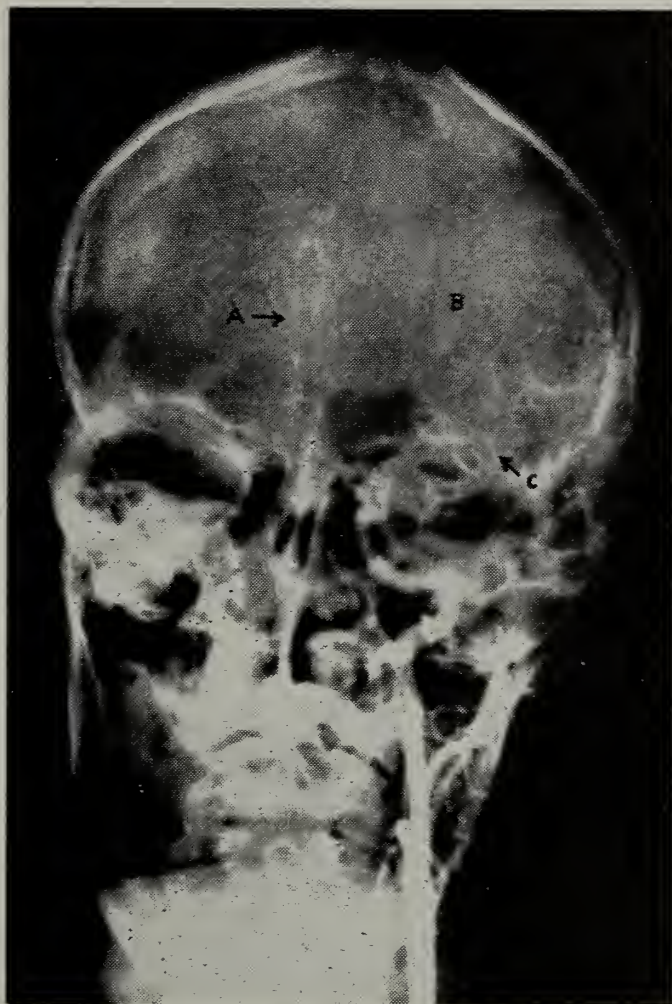


Arteriovenous malformation

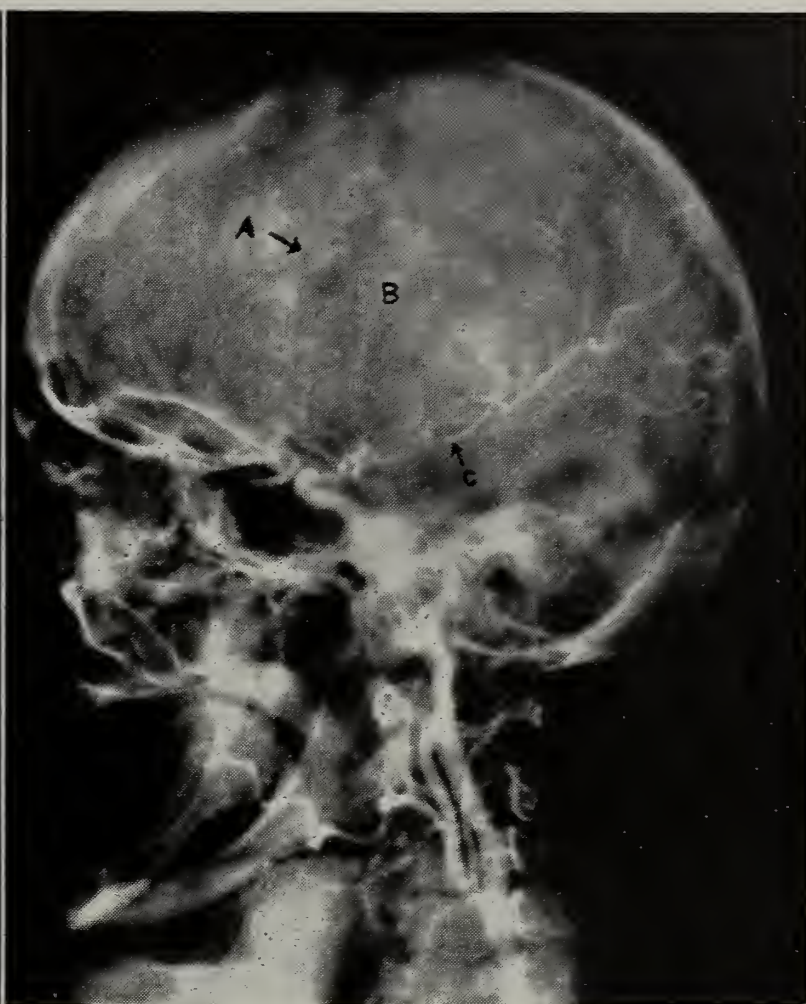


Saccular aneurysm internal carotid artery

FIGURE 1



Anteroposterior angiogram with displacement of anterior cerebral artery (A) across midline and tumor stain (B) involving domain of middle cerebral artery (C).



Lateral Angiogram showing displacement of middle cerebral artery (C) inferiorly by tumor mass (B) and upward displacement of anterior cerebral artery (A).

FIGURE 2

into the lumen of the common carotid artery and the radio-opaque medium is injected after the same principle noted above. At the time of injection, serial x-ray exposures of the skull in the standard anteroposterior, lateral and oblique^{3,4} positions are made. The percutaneous method is preferable whenever possible, since an operative procedure is thereby eliminated.

The type of anesthesia employed for angiography varies from clinic to clinic. Either general or local anesthesia may be employed and each has its merits. However, the advantages of local anesthesia, I believe, far outweigh those of general anesthesia. The patient may be observed during the procedure and complications anticipated. Furthermore, the possibility of anesthetic complications is eliminated. There is no alternative, however, for general anesthesia in the agitated patient with a low threshold for pain or in children.

With regard to material used, diodrast® in a concentration of 35 per cent is almost universally employed. Nevertheless, in spite of its apparent popularity, this drug is far from ideal. We have all been confronted with bizarre sequelae with the use of diodrast®, observing such distressing results as transient hemiplegias, sensory phenomena, convulsions, and especially, exaggerations of neurological phenomena already present. Even death has followed its use. With its faculty

for producing extreme degrees of vasospasm, visible to the operator at the time of the procedure and manifested by blanching of the face, one might readily anticipate the development of morbid phenomena in the cerebrum.

GENERAL CONSIDERATIONS

Neurological surgery has matured under the influence of cerebral angiography and pneumography, and it is unlikely that any diagnostic procedure developed in the future will supplant either of them. While we are headed into the atomic age, which, from a medical standpoint, means development to a high degree of tracer and ultrasonic techniques, such advancements cannot do more than supplement procedures wherein direct visualization of a pathological process may be obtained. It follows, therefore, that we should not be satisfied with the present state of development of cerebral angiography and air study, and that every possible avenue of research and clinical study should be explored again to remove the risks attendant to these procedures. The following avenues of approach for resolution of the problems which we face in angiography are rational:

(1) Operative technique in either the open or closed method can hardly be improved upon, except at the individual level as experience increases. However, from the standpoint of com-

fort to the patient and facility of accomplishment of a satisfactory study, more careful attention to infiltration of the paracarotid structures with local anesthetic agents is very important. While it is recognized that attack on the sympathetics to the head and its contents does not produce a comparable response to that in the extremities, at least blockade of the cervical sympathetics (stellate ganglion) tends to eliminate severe pain that accompanies the injection of an irritating medium into the carotid artery, substituting for it a subjective complaint of heat.

(2) Since diodrast® has been demonstrated to be a very irritating medium,² every effort should be made to find a satisfactory substitute just as radio-opaque, but without its damaging qualities of ability to produce direct toxic effect on nerve cells,² extreme degrees of vasospasm, alterations of vascular permeability, and cerebral electroactivity,¹ any one or all of which might result in serious disability and even death to the patient. Recent evidence⁵ suggests urokon® in 30 per cent concentration to be superior to diodrast®, but further clinical trial is needed before final evaluation of this drug can be made. Thorotrast®, although abandoned as a contrast medium because of its radioactivity and sarcogenic properties, merits fresh consideration. This medium, the least irritating of all agents used to date, could with advantage be reserved for the aged and patients with vascular occlusive disorders.

(3) Attention might also be directed to such other details as saline and its contamination by powder, gauze and cotton lint, and serious consideration given to the possibility, lest we condemn the contrast medium unjustly, that these agents as well as air and clot might occasionally act as emboli and account in part for the distressing sequelae of this procedure.

(4) Greater effort might be directed to development of mechanical seriographic x-ray devices with standardization of angiography with regard to the various phases of vascular filling as the ultimate aim. Therein lies the answer to accurate preoperative tumor diagnosis and recognition of the smaller vascular anomalies not now recorded because of incomplete studies.

(5) Radiation to the operator and other personnel should receive the skilled consideration of the roentgenologist and methods of uniform protection devised.

With time and patience, cerebral angiography will fully mature and with this growth will develop a broader knowledge of cerebral circulation, more exacting diagnosis and consequently increased skill in management of cerebral vascular lesions.

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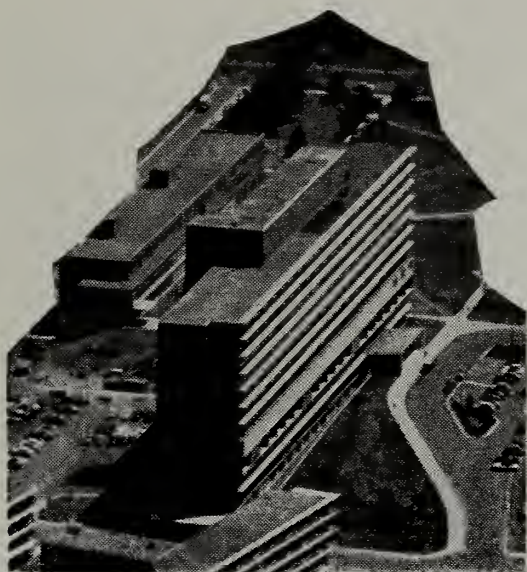
Accident Prevention In Childhood

Accidents are the leading cause of death in the 1 to 14 age groups, exceeding in frequency the next six most frequent causes. Each year in the United States there are an estimated two million child accidents which require medical attention. Twelve thousand or more of these accidents result in death and 40 to 50 thousand in injuries of a permanent nature. Child accident reduction is an obvious challenge to all groups and individuals in the United States who are interested in child life conservation. . . .

In a series of 491 nonfatal home accidents involving children and investigated in Rochester, New York, 48 per cent were judged to be preventable. It would appear that boys require more close attention since studies indicate that the male is most accident prone.

Bain reports that 400 children under 5 years of age die annually in the United States from poisoning. Aspirin, barbiturates, kerosene, lye, lead, and arsenic account for two-thirds of the deaths. In the state of Illinois in 1953 a total of 5,375 accidental deaths in persons of all ages was reported. Of these 2,299 resulted from motor vehicles. Of the 3,076 deaths not due to motor vehicles 1,547 occurred at home. Zook, in a study of costs of hospitalized accidents, many being burns, to a single agency caring for children (Division of Services for Crippled Children, University of Illinois) noted that the average cost per child to the State of Illinois was \$713.43. Dollars and cents figures, of course, fail to tell the complete story but are indicative of the tremendous economic losses from accidents. . . .

It is the responsibility of the medical and nursing professions, particularly those sections most interested in child welfare and public health, to assume leadership in all efforts directed toward prevention of accidents in childhood.—James B. Gillespie, M. D., Urbana, Ill.: *Illinois M. J.*, 108: 327, December, 1955.



A Case Record

From The University Hospital,
Columbus, Ohio

Edited Under the Auspices of the Ohio Society of Pathologists

Philip Wasserman, M. D., President

Presented by William F. Ashe, M. D., and Emmerich von Haam, M. D.

Edited by Dr. von Haam

PRESENTATION OF CASE

A FORTY-TWO year old white female was admitted to University Hospital with the chief complaint of increasing weakness over the past three weeks, bleeding of the mouth for one month and cough for one year. The cough was dry, hacking and nonproductive and associated with anterior chest pain. Six weeks prior to admission the patient noted a rash over the bridge of the nose, the malar areas, chin and exposed portion of the neck and upper chest. One month prior to admission the patient's gums began to bleed; this persisted to the time of admission.

The patient denied hemoptysis, hematemesis, tarry stools, purpura and vaginal bleeding. She stated that she had had shortness of breath on exertion for the past three weeks, without ankle edema, paroxysmal nocturnal dyspnea or orthopnea. She had been unable to retain solid food for the past two to four months but had retained liquids. She had sustained a bruise of the left forearm when she fainted and fell against an electric iron four weeks before and a bruise of the left hip in a fall several days before admission.

Physical examination revealed a pulse of 132, blood pressure of 110/64, respirations 28 and temperature 102°F. The patient appeared acutely ill, mildly dehydrated and was lying quietly in bed coughing or occasionally softly moaning. She was mentally clear but moderately apprehensive. Examination of the skin showed a blotchy, slightly scaly erythematous rash with many areas of telangiectasia covering the face in butterfly-winglike fashion and extending over the left side of the neck and upper chest. Dry dark blood covered the gums and lips, with numerous petechiae on the soft palate, lips and

buccal mucosa. Examination of the heart revealed a Grade II to III systolic murmur which was audible over the entire precordium. Examination of the lungs revealed dullness to percussion over the right upper lung field anteriorly and posteriorly with amphoric breath sounds in the same area. The remainder of the physical examination was essentially negative.

The red blood cells numbered 3.17 million, hemoglobin 6.9 Gm.; there were 3 per cent reticulocytes and 69,730 platelets; the white blood cell count was 14,600 with 83 per cent neutrophils, 7 per cent small lymphocytes and 10 per cent monocytes. The bone marrow contained predominantly polymorphonuclear leukocytes and myelocytes C; the erythroid elements were mostly at the normoblastic level. In two preparations cells suggestive of lupus erythematosus were found. A good number of normal megakaryocytes were seen. The urine contained 160 mg. of protein with many white blood cells per high power field in the sediment. Urine culture grew hemolytic *S. aureus* and enterococci. The blood urea nitrogen was 26 mg., the potassium 2.4 mEq. Sputum examination was negative for acid-fast bacilli. Cultures of blood and sputum grew pneumococcal organisms and *Proteus*.

The x-ray examination of the chest revealed a triangular infiltrate in the right upper lobe and increased peribronchial streaking throughout the lung fields. An electrocardiogram on the 15th hospital day was interpreted as abnormal with nonspecific T-wave changes in V-4, 5 and 6, possibly indicative of anoxia or ischemia.

The patient was started on 2000 cc. of glucose daily containing 50 mg. of ACTH, together with streptomycin and penicillin. Four days after admission her temperature had returned to normal; she was still very weak but appeared much less toxic and her gums had ceased to bleed. The patient was started on acthar® gel intra-

Submitted December 20, 1955.

muscularly, 20 units daily, and her symptoms improved remarkably. Cortisone therapy was started on the 21st day with 100 mg. twice a day, while acthar® gel was continued. She also received potassium chloride orally because of her low serum potassium.

In the fourth week the patient developed a painful cellulitis of the right forearm, elbow and upper arm with phlebitis and large tender axillary lymph nodes. A few days later the hemoglobin was found to be less than 7 Gm., and the patient received several blood transfusions. Later her cellulitis and phlebitis subsided but a large fluctuant mass remained on the inner aspect of the right upper arm. This was incised and drained 50 to 75 cc. of necrotic material and blood clots. The patient was finally discharged 42 days after admission, with a prescription for 50 mg. of cortisone daily.

SECOND ADMISSION

Ten days after her discharge the patient was admitted to the surgery service because of pain in both hips with swelling and tenderness. The physical examination revealed abscesses in the upper outer quadrants of both buttocks. The patient's temperature was moderately elevated. The red blood count was 2.32 million with hemoglobin of 7.7 Gm.; the white blood count was 9,080 with 87 per cent neutrophils, 12 per cent lymphocytes and 1 per cent basophils. Under local anesthesia the abscesses were incised and drained. The patient received several blood transfusions and was again started on cortisone therapy. She was discharged eight days later with instructions to return to the outpatient clinic.

THIRD ADMISSION

The patient was readmitted to University Hospital seven months later with the chief complaint of left chest pain for two to three days. She had been fairly well until about two weeks prior to admission. However, she had not taken her cortisone for some months. About two weeks prior to admission she began to have periods of disorientation. She complained of pain in the throat and inability to swallow and had taken no solid food since then. She also complained of pain anterior to the left ear. She developed a cough productive of minimal amounts of blood-streaked sputum. For five days prior to admission she had been extremely irrational and complained of pain in the lower left chest.

On physical examination the patient appeared undernourished, disoriented and dehydrated, with reddish peripheral ecchymosis of the dorsal aspects of both wrists and scattered petechiae over the entire trunk. Examination of the chest revealed rales at both bases and a pleural friction rub at the right axilla. A pericardial friction rub and a Grade II apical systolic murmur could also be heard over the entire precordium

with a systolic gallop rhythm. The liver was tender and could be palpated 4 cm. below the costal margin. The neurological examination revealed no localizing signs.

The red blood count was 1.79 million with 5.8 Gm. of hemoglobin; the white blood count was 31,250 with 92 per cent neutrophils and 8 per cent lymphocytes. The leukocytes showed severe toxic granulations. The blood platelets numbered 30,000. The prothrombin was 65 per cent of normal. The bleeding time was 2 minutes, 20 seconds; the coagulation time was 3 minutes, 30 seconds.

The urine contained 8 to 15 white blood cells and 4 to 8 red blood cells per high power field and 100 mg. of protein. The blood urea nitrogen was 158 mg. The inorganic phosphorus in the serum was 10.8 mg.; the total serum protein content was 6.1 per cent with 2.9 per cent albumin and 3.2 per cent globulin. The serum sodium was 148 mEq., the potassium content 6 mEq., the serum chlorides 113 mEq. The van den Bergh reaction was 0.4 direct and 1.2 mg. indirect. The blood urea nitrogen ranged between 141 and 158 mg. The stool was guaiac-positive. Urine culture grew hemolytic *S. aureus* and enterococci.

THE ELECTROCARDIOGRAM

An electrocardiogram showed left axis deviation, prolonged AV conduction time and specific ST and T-wave changes. Chest film revealed prominent lung markings throughout both lung fields, most marked in the hilar regions and at both bases. The bronchovascular markings in both lower lung fields were hazy. The transverse cardiac diameter was approximately 25 per cent greater than that expected for the patient's size. Roentgenogram of the abdomen revealed increase in size of the liver and spleen shadows.

The patient remained extremely confused and anemic. She received 5 pints of blood. She was digitalized on admission, given intravenous fluids, mercurhydrin,® combiotic,® vitamins and started on 100 mg. of hydrocortisone intravenously followed by cortisone parenterally, 100 mg. 4 times a day. She continued to be disoriented and confused.

On the third hospital day the patient became more delirious and there was some swelling of the right angle of the jaw and an increased bleeding tendency throughout the skin. She developed marked swelling of the neck which gradually progressed up the right side of the head to the vertex of the scalp. She developed laryngeal distress and was intubated, which caused a moderate amount of bright red bleeding. Despite numerous blood transfusions the patient continued to bleed. The swelling of the neck and face continued to increase. The patient suddenly became dyspneic and cyanotic; the blood pressure became unobtainable and resuscitative efforts failed to

revive her. The last hospital stay was of only three days' duration.

CLINICAL DISCUSSION

DR. W. F. ASHE: This 42 year old woman, the mother of four children, had been well until approximately a year before she was admitted the first time to the hospital because of weakness, cough with anterior chest pain, and then development of a rash over her face and neck. She was bleeding from her gums and had lost a considerable amount of weight. In the hospital she was also found to have tachycardia, a low blood pressure, tachypnea and fever, and although she was mentally clear the patient appeared acutely and seriously ill. She had some evidence of consolidation in her right upper lobe, and the laboratory tests revealed anemia with leukocytosis and thrombocytopenia. Because of a positive blood and sputum culture of pneumococci, she was treated with antibiotics.

The appearance of *Proteus* in her blood is to me indication of her serious illness since it frequently appears in persons who are in a terminal state. Because it was felt that she had some type of collagen disease she was treated with ACTH and cortisone and apparently this treatment was remarkably successful. The consolidation in her right lung disappeared, her temperature improved, and after a brief bout of cellulitis, which probably was due to an infected injection site, she was discharged in good condition.

A couple of weeks later she came back to the hospital with abscesses in both buttocks apparently at the sites of previous injections, which were drained satisfactorily. You will note that on that admission she again had a severe anemia although it was not stated in her hospital chart whether she was bleeding from any orifice at that time.

The third admission was precipitated apparently by severe disorientation. She became confused, befuddled and sometimes even maniacal. She again began to bleed severely from her gums and developed petechial hemorrhages on various parts of her body. The heart appeared larger than it was on her previous admissions and a pericardial friction rub was present. The laboratory tests showed severe anemia with leukocytosis and thrombocytopenia. Her bleeding and clotting times were both described as normal. At this time it was evident that she was in severe uremia with a continuously elevated blood urea nitrogen.

Her third hospital admission was extremely short. She remained confused, anemic and profoundly uremic. She had several blood transfusions and then developed a swelling in her neck which caused severe respiratory embarrassment. The surgeons felt that because of her bleeding condition no surgical procedure should be attempted, and tracheal intubation was performed

by the Anesthesia Department. She became a very serious problem because she continued to bleed into her tube. She died with symptoms of severe cyanosis and dyspnea.

What disease process will produce weight loss, weakness, chest pain, rash over the face, inability to eat solid food, pericarditis, some changes in the myocardium, bleeding from all the orifices of her body, a low platelet count and uremia? The first thing which comes into our mind is disseminated lupus erythematosus. It would affect all the blood vessels and can produce pleurisy, pericarditis and renal disease with uremia, but there are two observations in this patient which do not fit this diagnosis. The first is that almost all patients with disseminated lupus erythematosus develop sometime in the course of the disease some evidence of arthritis, and there is no mention in the history of our patient of joint pain or muscle discomfort at any time. The second observation is that of her severe hemorrhages. In reviewing the recent literature which has summarized nearly 400 cases of lupus erythematosus I was unable to find a single one which bled to death. For this reason we must ask ourselves what other possibilities one might consider.

SCURVY?

I think that one condition which must be considered, and which could easily be overlooked in this day and age, is scurvy as described by John Lind in English sailors of the Mediterranean a couple of hundred years ago. We do not have an accurate description of this patient's gums, but in scurvy the gums are dark blue, puffy and become infected, fungating masses with a foul odor. It seems to me highly unlikely that such a condition could have existed in this patient without somebody describing it. Furthermore, scurvy also produces hemorrhages into joint spaces with hemoarthrosis, and thirdly, scorbutic patients develop large and painful sub-periosteal hematomas which can hardly be overlooked by the physician. So we can exclude scurvy for clinical reasons.

Multiple myeloma involving the bone marrow and destroying bone will produce most of the symptoms of this patient. The diagnosis ought to have been easily made at a later admission should it have been missed at first, because in that period of time the classical bone lesions would have appeared. Plasma cells should have been seen in the bone marrow even on her first admission and none were found at any time. Bence Jones proteins were also never present in the urine. Lacking this cytological and chemical evidence when we know it was looked for, and without any radiological signs of destructive skeletal lesions, it seems unwarranted to entertain such a diagnosis.

The various types of leukemic disorders should be readily diagnosed from the bone marrow

studies and can be excluded in our patient. Essential thrombocytopenic purpura and primary hypersplenism also have to be considered in the differential diagnosis, and in fact splenectomy was recommended by some consultant in our patient but was rejected due to the surgical risk involved. Her blood platelets were definitely decreased but her bleeding and clotting times were normal. The megakaryocytes in the bone marrow were not increased and the patient gave no history of having received dicumarol.[®] Her prothrombin time was not much below normal, and we can exclude vitamin K deficiency.

Thus we seem to be forced back to our original diagnosis of disseminated lupus erythematosus. I do not know why she never had arthritic symptoms. I think her hemorrhages can be explained by that disease because we know that it produces injury especially to smaller vessels. We also find thrombocytopenia, and often anticoagulating substances appear in the blood in increased amounts the nature of which is not known. Should this diagnosis be correct, Dr. von Haam will find in the brain vascular changes which will explain her delirium, even in the absence of uremia.

Because of her uremia I suspect that her kidneys will demonstrate the wireloop deformity that is seen in lupus and a good amount of renal hemorrhage. In the lungs I think he will find alveolar hemorrhage and vascular changes. There will probably be some kind of pericarditis present and the myocardium will show vascular changes. I do not know why this patient exsanguinated terminally. I have never seen or heard of a similar type of death in lupus, but this cannot influence my diagnosis.

CLINICAL DIAGNOSIS

1. Disseminated lupus erythematosus.
2. Uremia.
3. Death by exsanguination.

PATHOLOGIC DIAGNOSIS

1. Disseminated lupus erythematosus.
2. Bronchopneumonia.
3. Chronic glomerulonephritis.
4. Uremia.
5. Generalized purpura.

PATHOLOGIC DISCUSSION

DR. E. VON HAAM: The autopsy showed an emaciated woman who showed extensive petechiae all over the skin and a swollen, diffusely purpuric neck. The rash over the face was not visible after death. There was mild generalized adenopathy. The abdominal cavity contained 2000 cc. of clear amber fluid. The pericardial surface of the heart was covered with a fibrinous exudate. The heart was not enlarged and all valves seemed to have functioned normally. The lungs were heavier than normal. All the bronchi were filled

with frothy blood-tinged fluid and the lung parenchyma showed patchy congestion.

The liver and spleen were only slightly enlarged and appeared grossly normal. The mucosa of the esophagus was severely ulcerated. The stomach contained about 200 cc. of coffee-ground-like material. The mucosa of the entire gastrointestinal tract showed many petechiae but no bleeding ulcers could be discovered. The colon contained fresh and altered blood. The kidneys were slightly enlarged, pale and granular. The cortex showed many petechiae. Dissection of the swollen, purpuric neck showed a large hematoma which extended between the structures of the neck. The brain appeared swollen and pale; the gyri were edematous, the sulci thin and compressed.

MICROSCOPIC EXAMINATION

Sections through the lungs showed small foci of bronchopneumonia. The spleen showed the typical perivascular fibrosis characteristic of lupus and a very marked degree of extramedullary hematopoiesis. Sections through the intestines revealed only many petechiae without ulcerations. Sections through the kidneys showed a proliferative glomerulonephritis with fibrinoid degeneration of many capillaries and smaller vessels. There were many so-called "wireloop" formations and all tubules contained protein and red blood cell casts. Petechiae were microscopically present in nearly all organs examined including the bronchial mucosa, the urinary bladder and the brain. The bone marrow showed a diffuse hyperplasia of erythroid and myeloid elements.

From these findings we concluded that the patient died from collagen disease which was particularly characterized by a pronounced bleeding tendency. The question has been raised by Dr. Ashe whether this patient bled to death. We feel that she died principally from her uremic condition and that her mental confusion was mostly due to the cerebral edema caused by her uremia. Her anemia which was so impressive at her third admission resulted from loss of blood rather than from toxic depression of the bone marrow or from lupus of the marrow.

The loss of blood occurred mainly through the intestinal mucosa and through the kidneys. The latter showed all evidence of an acute collagen disease together with a glomerulonephritis of the proliferative and sclerosing type. The occurrence of both lesions in the kidneys of a patient with lupus erythematosus is not an unusual observation, as Klemperer has always emphasized, and leads to the development of a steadily progressive chronic uremia. Hemorrhagic lupus is rare, and I agree with Dr. Ashe that bleeding to death in lupus erythematosus is practically never observed.

This case demonstrates what varying clinical

pictures the group of collagen diseases can make and how difficult their differential diagnosis can be.

GENERAL DISCUSSION

DR. ASHE: Dr. von Haam, is there any possibility at all that a drug sensitivity was at the bottom of her condition?

DR. VON HAAM: My experience would not agree with that. Drug sensitivities usually produce vascular changes affecting the larger blood vessels. They also show a much more violent and acute course and do not assume a chronic character such as was present in our patient. However, it is true that acquired drug sensitivities will imitate collagen diseases and this is important in view of the increasingly frequent occurrence of both conditions.

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Fungous Infections Of the Hands

Superficial fungous infections of the hands are so rare as scarcely to justify the common misconception that eczema of the hand is "fungous" until proved otherwise. . . .

Secondary fungous eruptions are not rare and may result from the hematogenous spread of fungi or transmission of these toxins from foci of feet, groin, or ears. The criteria for such a diagnosis have been listed by Sulzberger and Baes:

- (1) There should be a demonstrable focus of primary fungous infection.
- (2) Onset of eruption on the hands should follow activation or irritation of the primary focus.
- (3) Eruptions on the hands should be symmetric and should occur on the sides of the fingers, thenar and hypothenar eminences, and palms.
- (4) The eruption should subside as the primary focus is controlled.
- (5) Forty-eight to 72 hour tuberculin type reaction to skin testing with trichophyton should be positive.—James W. Burks, Jr., M. D., New Orleans: *J. Oklahoma State M. A.*, 48:208, 1955.

Cat Scratch Fever

Cat scratch fever is a disease entity about which little is known. Fifty per cent, or more of cases in humans follow cat scratch, but nothing is known concerning the etiological agent, how this affects the cat, or how it is transmitted among animals. — "Healthy Animals — Healthier Humans," *WHO Newsletter*, vol. 8, Nov.-Dec., 1955.

KEEPING UP WITH MEDICINE

• RICHARD BRIGHT, in his classical description of glomerulonephritis, recognized its association with upper respiratory infections.

* * *

• THE LATENT PERIOD between the respiratory infection and the onset of clinical symptoms of glomerulonephritis plus the demonstration that no bacteria are found in the kidneys of patients with acute glomerulonephritis suggests strongly that the disorder is a manifestation of an antigen-antibody reaction—somehow set off by a group A hemolytic streptococcus infection.

* * *

• ANEMIA of advanced glomerulonephritis may become severe and be one of the most important contributors to the patient's weakness, dyspnea, and other symptoms.

* * *

• THERE IS the growing belief that overweight *per se* is not the cause of coronary disease.

* * *

• IT SEEMS POSSIBLE now that there is a relationship between magnesium metabolism and thyroid function. At any rate there is some similarity between the symptomatology of hyperthyroidism and that of magnesium deficiency on the one hand and that of hypothyroidism and dietary magnesium excess on the other.

* * *

• SINCE MANY human dietaries contain protein with abnormally high concentrations of certain amino acids, consideration of amino acid antagonisms might suggest which amino acids would be the most effective supplements for the diets.

* * *

• MOST AUTHORITIES are now emphasizing the growing importance of mineral elements in regard to basic physiology at all levels from plants to the problems of human health.

* * *

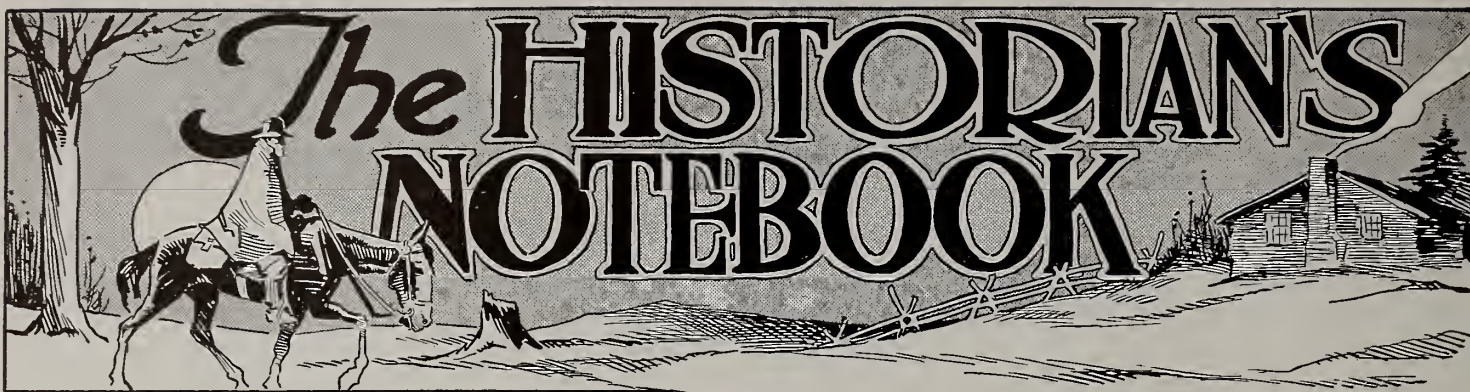
• EXPERIMENTAL NEPHROSIS can be looked upon as "protein diabetes."

* * *

• THERE IS every reason to believe that many of the adolescent girls of our day get less than 50 per cent of the essential nutrients for optimal health and these are to be mothers in just a few years. No matter how good a diet is provided during their pregnancies it can never make up for all that has been lost in the foolish diets of their girlhood.

* * *

• ONE INSTANCE the physician must bear the responsibility of the spreading of viral hepatitis is as he makes use of blood and blood products or improperly sterilized equipment in treating other diseases.—J. F.



The Northside Medical Research Society: 1908 - 1910*

JONATHAN FORMAN, M. D.

(Continued from February issue)

MAY, 1908

“AT THE meeting of May 12th, 1908, held at the Northern Hotel, Dr. C. A. Howell delivered a lecture on ‘Reflexes,’ illustrated by many charts artistically painted especially for this meeting. Dr. Carlton also read a paper on ‘Typhoid Fever and Its Treatment.’ Drs. Taylor and Townson reported the case of a young woman whose trouble could not be accurately diagnosed. She died within a few days and the autopsy disclosed a tumor of her heart. The pathologic specimen was demonstrated to the group.

JUNE, 1908

“At the June meeting, Dr. George C. Shaffer read a paper on artificial infant feeding and Dr. Ernest Scott spoke on the milk supply of Columbus. His paper, which was said to be well above the average from the viewpoint of practical investigations and research, was discussed by W. D. Inglis, E. G. Horton, and J. S. Carlton. As a result Dr. Horton offered the following resolution:

“‘RESOLVED that in the opinion of the membership of the Northside Research Society, the time has come when the Columbus Academy of Medicine should appoint a Milk Commission for the City of Columbus and such action by the Academy is respectfully urged.’

“The resolution was adopted. Dr. Horton for the Committee on Credit Rating then reported that the Physicians’ Collecting Agency of Columbus would, for fifty cents per member, prepare a credit rating list to be put in the hands of each member. This proposition was accepted.

*I have recently had access to the minute book of this society of nearly 50 years ago. The subjects discussed and the viewpoints expressed give such a clear insight into the status of medical practice of two generations ago that they seem worthy of publication as valuable source material.

The Author

● Dr. Forman, Columbus, is Professor of the History of Medicine in The Ohio State University.

JULY, 1908

“To this meeting all of the physicians of the city and vicinity were invited. About 100 came. After an excellent lunch, Dr. A. Ravogli, the well known dermatologist of Cincinnati, and a member of the State Medical Board, gave a lecture on ‘Syphilis,’ illustrated with lantern slides.

SEPTEMBER, 1908

“Dr. Thomas Hoover, chief of staff at St. Francis Hospital, talked on ‘Fractures.’ The group showed their appreciation by asking many intelligent questions which were cheerfully and satisfactorily answered by the guest speaker.

“On the business side of practice, the fee for a vaccination was set at 75¢.

OCTOBER, 1908

“Mr. Johnson of The Merchants’ Collecting Company was introduced and told of their facilities for furnishing credit ratings. On motion by Dr. Howell, seconded by Dr. Gordon, the Society was advised to purchase the 1907 and 1908 editions of this company’s Credit Rating Lists.

“Dr. T. E. Courtright read a paper on Medical Ethics. The following resolution was adopted: ‘Whereas Dr. John E. Hanes, an ethical physician of the Northside Research Society, the Columbus Academy of Medicine and also of the State and American Medical Associations, is a

candidate for the important office of Coroner of Franklin County,

"Therefore, Be It Resolved, that this Society pledge Dr. Hanes our hearty support for the office he seeks." (Carried.)

NOVEMBER, 1908

"Those present were Drs. C. A. Howell, R. R. Taylor, J. M. Thomas, J. S. Carlton, J. D. Gordon, J. A. McClure, J. F. Jones, L. W. Neiswander, E. S. Oman, E. W. Evans, and Miss Blackburn. Dr. Ralph Taylor read a paper on 'The Treatment of Pneumonia,' which was discussed by Drs. McClure, Van Fossen, Oman, Blackburn, and Howell.

DECEMBER, 1908

"Dr. W. D. Inglis read a paper on 'Ante Partum Hemorrhage' and Dr. H. H. Snively one on 'Post Partum Hemorrhage.' These papers were discussed by Drs. Howell, McClure, Clark, and Lisle. After this officers were elected for the coming year. J. F. Jones, President; J. A. McClure, Vice-President; John Gordon, second Vice-President; Earl Evans, Treasurer; and L. W. Neiswander, Secretary. The Executive Board to be comprised of Dr. Darlington, J. Snyder, C. A. Howell, J. S. Carlton, W. D. Inglis, and J. F. Jones (ex-officio). Committee on Membership, Drs. J. S. Carlton, A. C. Wolfe, and H. H. Snively. After passing a resolution of thanks for free use of the parlors of the Northern Hotel, the Society adjourned.

JANUARY, 1909

"E. F. McCampbell, Ph.D., read a paper on 'Anaphylaxis With Special Reference To Immunity.' The paper was discussed by Dr. J. McL. Philips and Ernest Scott. This was by far the best program on medical research so far enjoyed by the Society. There were 34 members and six visitors present.

FEBRUARY, 1909

"'Traumatic Neurosis' was the subject presented by Dr. Earl Gaver. Dr. Gaver placed special emphasis on the medico-legal aspects and recommended certain reform measures. His paper was discussed by Dr. C. A. Howell, Dr. George T. Harding, and Judge E. Kinkead, Attorneys Seymour, Tussig and W. J. Means. Eighty-five Physicians and Lawyers from all over the city were in attendance.

MARCH, 1909

"'Careless Diagnoses In General Practice' was the subject of a thoughtful paper by J. A. McClure. The paper did not criticise the medical profession but it did point certain mistakes due to carelessness and emphasized the importance of giving every patient a careful examination. It was discussed by Drs. Kinsman, Frank Winders, J. S. Van Fossen, and C. A. Howell.

MAY, 1909

"D. N. Kinsman addressed himself to the general practice of medicine. He discouraged the use of proprietary medicines and said that not one in 20 contained the ingredients in the proportions indicated on the label. He gave the therapeutic action and indications for many of the common drugs and cited instances of the wrong application of these drugs.

"The future of the Society came in for discussion. A strong sentiment was evident in favor of an earnest and systematic study but the details to be worked out were left to the next meeting.

"On motion of Dr. F. F. Lawrence, seconded by J. M. Thomas, the following resolution was adopted without a dissenting vote:

"RESOLVED that the Northside Research Society recognizes the necessity for medical inspection in the Public Schools and urges the Board of Education to take steps to provide the same.'

"On motion by Dr. M. E. Blackburn, seconded by J. M. Thomas, and adopted without a dissenting vote was the following:

"RESOLVED that the Northside Research Society most heartily endorses the action of the Mayor and city officials in their attempt to protect the children of our city from the dangers of hydrophobia by establishing the dog pound and ordering stray dogs to be impounded or killed.'

JUNE, 1909

"This was a business meeting to discuss changes in the plan of conducting the meetings of the Society. As a result the president was empowered to appoint a committee to draft a plan for the future. He appointed C. A. Howell, L. W. Neiswander, and A. C. Wolfe.

OCTOBER, 1909

"This was a special meeting to hear Dr. Frank Lydston, of Chicago, talk on 'The Evolution of Medical Despotism in America with Certain Non-Official Remedies Therefor.' This was a banquet in honor of the speaker with some 150 present.

"The regular October meeting was held on the 19th at which Dr. C. A. Howell read a paper, 'Studies on the Peritoneum.' In the opinion of the secretary in minutes later approved by the Society, 'this was the best research paper read by a Columbus physician.' Fifty physicians were present.

DECEMBER, 1909

"A beautiful floral offering was sent as a tribute of love and sympathy to Dr. John Gordon upon hearing of the death of his beloved wife.

FEBRUARY, 1910

"An election of officers at which J. A. McClure was elected President; G. K. Coleville, Vice-

President; Earl W. Evans, Treasurer; and Adam Elder, Secretary.

APRIL, 1910

"The paper of the evening was by Hon. H. G. Booth, attorney of Columbus. Its title was 'Street Railway Accidents—The Duty of the Physician to the Corporation and to the Community.' Discussion was by Drs. Howell and Hanes.

MAY, 1910

"Dr. Roy McClure, (later to become head of the Ford Hospital in Detroit—Ed.), spoke on 'Blood Transfusions.' (The speaker was also the son of the president.) He drew a large crowd. Discussion was by Drs. Bleile, J. F. Baldwin, and Van Fossen.

JUNE, 1910

"The program consisted of a paper by Dr. J. A. Riebel on 'The Etiology, Pathology and Treatment of Gonorrhea'; 'The Sequelae of Gonorrhea,' by Dr. Sylvester J. Goodman; 'The Education of the Youth Concerning the Evils of the Disease,' by W. O. Thompson, President of Ohio State University, and Hon. George S. Marshall. General discussion was opened by Dr. C. S. Means.

"Proper action was taken concerning the death of Mrs. Earl Evans."

AND HERE ENDS THE MINUTES

(Now owned by a grandson of Adam Elder, the last Secretary of record.)

Theodoric Surgery, Ca. AD 1267, Vol. 1, Books 1 and 2, Translated from The Latin by Eldridge Campbell, M. D., and James Colton, M. A., (\$5.50. *Appleton-Century-Crofts, New York 1, N. Y.*). This book is of interest to the modern surgeon, not only for its contents but also for the picture which it affords of medieval surgical thought and practice. The resources of medicine were said to be three—diet, drugs, and surgery, the last to be resorted to only when the others were inadequate. "Surgeons must needs be well read, for even though they be experienced, they will frequently fall into error and confusion, and I think that no one can understand surgery with letters."

Paul Ehrlich—Man and Scientist, Occasional Contribution No. 68, by Ernst Jokl, M. D., (Apply. *University of Kentucky Libraries, Lexington, Kentucky*). An appreciation of Ehrlich by a friend of the family. He draws an inspiring sketch of the man and his philosophy.

There are definite indications that King Merneptah, the Pharaoh of the Hebrew Exodus suffered from atherosclerosis. Interestingly enough, studies of ancient mummies reveal its presence in the bodies of all ages. It is indeed one of the oldest of diseases.

The Story Behind the Word

Some Interesting Origins of Medical Terms

Abort—Literally meaning to be kept "from being born," this term is derived from the Latin word "abortus" or miscarried. This in turn is derived from the Latin words "ab" or from, plus "oriri" meaning to be born. The term "oriri" is derived from the Latin word "orior," meaning "I arise."

Pregnant—Derived from the Latin word "praegnans" meaning "being with child," this term is composed of the Latin words "prae," or before, plus "gnatus or natus" meaning birth. Hence the term literally means "before birth."

Physician—The physician derives his name from the Greek word "physis," or nature and the Greek term "physike" meant a knowledge of nature. Included under nature were all of the natural sciences including biology and medicine. Because the teaching of medicine came under the general heading of "physicus," the practitioners of this natural science became known as physicians. The term came into English via the French in about the thirteenth century.

Phren-Phrenic—The Greek word "phren or phrena" had two meanings; it designated both the mind and the diaphragm. This arose from the ancient belief that the mind was situated in the diaphragm, because they noted that sensations of emotion and agitation occurred in this region.

Phallus—Denoting the penis, this term is also used in embryology to designate the embryonic structure derived from the genital tubercle which in the male differentiates into the penis and in the female differentiates into the clitoris. The term is derived from the Greek word "phallos," which was applied to the penis, or to a figure of it which was borne in the pagan Bacchic processions as an emblem of worship to the procreative powers of nature.

Pertussis—This term is the scientific name for whooping cough and literally means "to thoroughly cough." It is derived from the Latin "per," or thoroughly, and "tussis" or cough.

Perineum—The ancient Greek word "perinaion" was used by Hippocrates and has descended to us almost unchanged. It designates the space between the anus and the scrotum in the male and the space between the anus and the posterior commissure of the vulva in the female. The word is of uncertain derivation and may be derived from the Greek prefix "peri" meaning around or near, plus the Greek word "naio" meaning, "I inhabit." It may also come from the Greek word "naos" meaning a place of worship or a temple and hence may refer to phallic worship in the sense that this anatomical area is near or about a place of worship, the phallus.

—HARRY WAIN, M. D., Mansfield, Ohio.

New Members of O. S. M. A.

The following are the names of the new members of the Ohio State Medical Association since January 1st, 1956. The list shows the county in which they are affiliated, city in which they are practicing, or temporary address in cases where physicians are taking postgraduate work.

ALLEN COUNTY

Patrick A. Connaughton,
Lima
Raymond B. Croissant,
Lima
John D. Hubbell, Lima
William T. Wright,
Spencerville

ASHTABULA COUNTY

James R. Atkinson,
Ashtabula
Philip C. Brunori,
Ashtabula

ATHENS COUNTY

William H. Allen, Jr.,
Nelsonville
William F. Doran,
Nelsonville
Ruth Matthewson, Athens

BUTLER COUNTY

Anthony G. Kokinakis,
Middletown
James R. Simpson,
Hamilton
Robert J. Walker, Jr.,
Hamilton

CLERMONT COUNTY

Stephanus J. Abraham,
Batavia

CLINTON COUNTY

David L. Hamilton,
Wilmington

CRAWFORD COUNTY

William C. Manthey,
Galion
Francis E. Moore,
New Washington

CUYAHOGA COUNTY

Andre Callot,
Brecksville
William Henry Cope,
Cleveland
Robert J. Corday,
Cleveland
Nadene Coyne, Cleveland
Robert L. Custer,
N. Royalton
Harry Goldblatt,
Cleveland
Joseph C. Hadden, Berea
Claire M. Hirsch,
Cleveland
Anne B. Johnson,
Cleveland
David T. Kaung, Cleveland
Thomas R. Nolan,
Cleveland
Zoltan Peller, Cleveland
Frederic W. Rhinelanders,
Cleveland
Oscar A. Ross,
University Heights
Morton Sass, Cleveland
Leo Stanley Szakalun,
North Olmstead
Robert J. Wallace,
Westlake
Stanley F. Wallace,
Cleveland
Marvin L. Whitman,
Cleveland
Michael R. Zeiger,
Cleveland

DEFIANCE COUNTY

William S. Busted,
Defiance

FAIRFIELD COUNTY

Harold J. Schwendeman,
Lancaster

FAYETTE COUNTY

Robert U. Anderson,
Washington C. H.
Philip E. Binzel,
Washington C. H.

GALLIA COUNTY

Martin K. Rosenbaum,
Gallipolis

HAMILTON COUNTY

Owen C. Clark,
Cincinnati
Stanley M. Kaplan,
Cincinnati

HOCKING COUNTY

Wyant J. Shively, Logan

HURON COUNTY

John Gardiner III,
Norwalk
Otto F. Lanka,
New London

LAKE COUNTY

Frank W. Laird, Jr.,
Madison

LAWRENCE COUNTY

Ernest G. Rafey, Ironton

MAHONING COUNTY

Robert E. Carr,
Youngstown
Charles N. Giering,
Youngstown
Norman E. Sharrer,
Youngstown

MARION COUNTY

Larry H. Birch, Marion
Thomas S. Lastrappes,
Marion
Gene Qualls, Marion
Glenn E. Willoughby,
Marion
Marvin B. Wolf, Marion

MERCER COUNTY

Robert F. Brashear,
Rockford
Terrence J. Kerrigan,
Coldwater

MIAMI COUNTY

Robert L. Girouard,
Covington
Carl G. Hoak, Troy
Edwin F. Luh, Piqua

MUSKINGUM COUNTY

Charles I. Cerney,
Zanesville

OTTAWA COUNTY

Victor Iskersky, Curtice
Donald F. Loeffler,
Oak Harbor
Robert Reeves,
Oak Harbor

PERRY COUNTY

Ralph E. Herenden, Jr.,
New Lexington

PIKE COUNTY

Benton V. D. Scott,
Waverly

Inter-Hospital Lectures on Heart Scheduled in Toledo

The Maumee Valley Hospital and the Northwestern Ohio Heart Association are joining forces to present the Inter-Hospital Postgraduate Lecture Series in Toledo, Thursday and Friday, March 29 and 30. Lectures will be held at the headquarters building of the Academy of Medicine of Toledo, 3101 Collingwood Blvd., Toledo.

Guest speaker to present the series of lectures will be Dr. William Likoff, chief cardiologist, Bailey Thoracic Clinic, Philadelphia, Pa. The talks will be on the general theme, "The Pathophysiology, Clinical Manifestations and Therapy of Congenital and Acquired Heart Disease."

The schedule for the lectures is as follows.

THURSDAY, MARCH 29

12 Noon—Right and Left Heart Catheterization. Techniques. Normal Values. The Pathophysiology, Clinical Manifestations and Therapy of Congenital Heart Disease. (a) Lesions Without Shunt.

4:30 P. M.—The Pathophysiology, Clinical Manifestations and Therapy of Congenital Heart Disease. (b) Lesions with Left to Right Shunt.

8:00 P. M.—The Pathophysiology, Clinical Manifestations and Therapy of Congenital Heart Disease. (c) Lesions with Right to Left Shunt.

FRIDAY, MARCH 30

12 Noon—The Pathophysiology, Clinical Manifestations and Therapy of Mitral Stenosis and Tricuspid Stenosis.

4:30 P. M.—The Pathophysiology, Clinical Manifestations and Therapy of Aortic Valve Disease: Aortic Stenosis, Aortic Insufficiency.

8:00 P. M.—The Pathophysiology, Clinical Manifestations and Therapy of Mitral Insufficiency, and Tricuspid Insufficiency.

(New Members of Association Cont'd.)

ROSS COUNTY

Stephen Fleischer,
Chillicothe
Gail Ann Locken,
Chillicothe
Lowell D. Smith,
Chillicothe

SCIOTO COUNTY

Robert N. Counts,
Portsmouth
Spencer William Miller,
Portsmouth

SHELBY COUNTY

Boyd L. Mahuron, Sidney

STARK COUNTY

Frank A. Gonzalez, Canton
Igor F. Nikishin, Canton
Richard V. Skibbens,
North Canton
Grace F. Thomas, Canton

SUMMIT COUNTY

Robert H. Baxter, Akron

TRUMBULL COUNTY

Ralph H. Jamison,
Warren
Harry H. Livingston,
Warren
Laurence L. Maggiano,
Warren
Edward B. McGovern,
Warren
John S. Schlecht, Warren

TUSCARAWAS COUNTY

John Andrea, Dover
Arthur J. Stevenson,
New Philadelphia

VAN WERT COUNTY

Alford C. Diller, Convoy
Norman L. Marxen,
Van Wert

WOOD COUNTY

Robert E. Boyle,
Bowling Green
Richard L. Pearse,
Bowling Green

(Continued in Next Column)

ACHROM

PHOTO DATA: CAMERA: 4X5 VIEW CAMERA; EXPOSURE 1/25 SEC. AT F.11 EXISTING LIGHTING.

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Mental Hygiene Building Program . . .

Special Session of Legislature Sets Program in Motion; Authorizes \$15 Million for Immediate Needs and Funds for Long-Range Planning

OHIO'S improvement and expansion program for mental hygiene institutions was officially set in motion by the special session of the Ohio General Assembly, January 16-18. In brief, the Legislature authorized the following: (1) Construction of new buildings with a total capacity of approximately 1,650 beds for mentally ill and mentally retarded patients and juvenile offenders, to be started this year if possible; (2) more than a million dollars to pay for working plans and specifications for further expansion proposed for 1957-1958.

The total amount appropriated to the Department of Mental Hygiene and Correction was fifteen million dollars.

The special session of the Legislature was mandated by provisions of the \$150 million mental hygiene and public education bond issue approved by voters at the November general election. The amendment specified that not more than \$30 million in bonds could be issued in any one year.

State supported universities and colleges received \$14,898,138 from the first year's bond issue money, and the new State Board of Education received \$7,100,000 for the current year from State's General Revenue Fund.

JUVENILE CENTER

Among the Department of Mental Hygiene and Correction projects provided for are Ohio's first psychiatric treatment institution for emotionally disturbed delinquent children, designed to accommodate 100 beds and to cost \$1,500,000; and a new 150-bed central reception and classification center addition to the state Juvenile Diagnostic Center in Columbus to cost a similar amount. The new institution will be under the Division of Juvenile Research, Classification and Training, a branch of the Department of Mental Hygiene and Correction.

An appropriation of \$1.5 million also was made for construction of a new 100-bed children's psychiatric unit at Dayton State Hospital. Dr. John D. Porterfield, director of the Department, said that this will be the first of five such units envisioned in the long-range improvement plan.

The appropriations toward the planning phases of the long-range program included the following: An appropriation of \$632,000 to the Division of Mental Hygiene to enable it to pay for working plans and specifications for projects proposed for 1957, and \$181,000 for preliminary plans for projects proposed for construction in 1958. The latter appropriation will provide for less delay

in getting projects started after the 1957 Legislature appropriates funds for that and subsequent years.

The Department's Division of Correction was given an appropriation of \$252,000 earmarked for working plans for a new "medium security" institution near Lebanon, to be known as the Southern Ohio Reformatory.

LIST OF PROJECTS

The following breakdown shows appropriations for institutions in the Department's Division of Mental Hygiene:

Columbus State School (for the mentally retarded): New centralized food preparation and service unit, \$1,400,000; Completion of 150-bed reception and diagnostic center, \$650,000.

Apple Creek State Hospital: New 100-bed "B" type patient building, \$350,000; New 120-bed center for the mentally retarded, \$1,000,000;

Hawthornden State Hospital: New 200-bed patient building, \$1,000,000; Expansion of central facilities, \$585,000.

Cleveland State Hospital: New 100-bed medical and surgical building, \$750,000.

Cleveland Receiving Hospital: Construction of additional floors to increase bed capacity of existing building, \$700,000.

Dayton State Hospital: New 100-bed children's psychiatric unit, \$1,500,000; Completion of 100-bed adult receiving hospital, \$250,000.

Toledo State Hospital: New 100-bed addition to receiving hospital and therapy unit, \$500,000.

Tiffin State Hospital: New 100-bed reception and intensive therapy unit, \$750,000.

Gallipolis State Institute: New 100-bed medical and surgical building, \$750,000.

Cambridge State Hospital: New 120-bed reception and intensive therapy unit, \$750,000.

Society for Crippled Children Sponsors 30-Day Campaign

The Ohio Society for Crippled Children has announced its annual Easter Seal campaign from March 10 to April 10. Last year a total of \$554,796.02 was realized in the Easter Seal campaign. Of that amount, 75 per cent remained in the area where it was given for direct services to handicapped children and adults. In addition, 8.3 per cent was channeled to the National Society for Crippled Children and Adults; 2 per cent to its research projects, and 15.7 per cent to the Ohio Society for Crippled Children.

Announcing

The Official Program

for the

1956 ANNUAL MEETING Ohio State Medical Association CLEVELAND

Tuesday - Thursday April 10, 11 and 12

HERE is a resumé of Annual Meeting highlights and an introduction to the program. Readers are invited to turn to the day-by-day charts—one each for Tuesday, Wednesday and Thursday—to pinpoint the events in which they are interested; note the time of events and then turn to the detailed chronological program for particulars.

Time and Place: Tuesday, Wednesday and Thursday, April 10, 11 and 12. Scientific programs, the Exhibits and other features will be in the Cleveland Public Auditorium, within easy walking distance of downtown hotels. The Annual Banquet, meetings of the House of Delegates and some other events are scheduled at the Hotel Statler, Euclid at East 12th Street.

Registration: Headquarters will be in the Main Entrance Lobby of the Cleveland Public Auditorium. Registration opens at 8:30 a. m. on Tuesday, April 10. Admission to all sessions and to the Exhibits will be by badge secured at time of registration.

Those eligible to register are Members of the Ohio State Medical Association (who should have 1956 Membership Cards for presentation at time of registration); physicians from other states who are members of their respective state medical societies; residents, interns, medical students, nurses, health workers, and other guests who are presented at Registration Headquarters by members. The Woman's Auxiliary will provide registration for its members and others who are eligible to attend Auxiliary sessions.

General Sessions: Subjects of broad interest to physicians in all branches of practice will be discussed at General Sessions on Wednesday afternoon and Thursday morning.

Specialty Section Programs: The following sections will conduct programs or participate in joint programs: Sections on Anesthesiology, General Practice, Internal Medicine, Nervous and Mental Diseases, Neurosurgery, Obstetrics and Gynecology,

Ophthalmology, Otorhinolaryngology, Pediatrics, Physical Medicine, Radiology, Surgery, and Urology. All physicians, regardless of whether or not they belong to the specialty, are welcome to attend these meetings.

Specialty Society Meetings: Several organizations have scheduled meetings to coordinate with the State Association meeting. Among these are the Ohio Academy of General Practice, Ohio Chapter of the American Academy of Chest Physicians, Ohio Society of Anesthesiologists, Ohio Chapter of the American Academy of Pediatrics, the Ohio Psychiatric Association. The Ohio State Surgical Association will meet at the Auditorium on Monday, April 9, the day before the OSMA Meeting. The Ohio State Heart Association will meet at the Hotel Statler, also on Monday.

Out-of-State Guest Speakers: The following, who are further identified in the detailed program, will be guest speakers: Lt. Col. Curtis P. Artz, MC, U.S. Army, Brooke Army Medical Center, San Antonio, Texas; Dr. Carl E. Badgley, University of Michigan; Dr. Hermann Burian, University of Iowa; Dr. Edgar Burns, Tulane University; Dr. D. Ewen Cameron, Montreal, Canada; Dr. Julian Johnson, Pennsylvania School of Medicine; Dr. Morton Marks, New York University; Dr. Donald L. McRae, McGill University, Montreal, Canada. Some of the Specialty Societies have additional guest speakers scheduled on their programs.

Scientific and Educational Exhibit: Here will be found graphic reports on the latest developments in research, medical investigation and clinical studies. Each exhibit will be manned by members of the sponsoring team who will discuss with visiting physicians the subject presented. Ample time has been provided throughout the program for frequent visits to the Exhibits.

Technical Exhibit: Detail men from leading pharmaceutical and other supply houses will be on hand to discuss the latest developments in their respective fields. Here again is an education in itself. Many visits can be made, each adding something to the physician's store of knowledge of the supply field.

House of Delegates: Representatives of each county medical society, District Councilors and other state officers, assemble as the policy-making body of the State Association. Two meetings are scheduled in the Hotel Statler—the first on Tuesday afternoon and the second on Thursday following luncheon. Although official participation is limited to delegates, any member of the Association is welcome to attend.

Medical Motion Pictures: A careful selection has been made of the many available pictures on up-to-date techniques and other phases of postgraduate education.

Woman's Auxiliary: The Woman's Auxiliary to the Ohio State Medical Association is holding its annual meeting in conjunction with the State Association meeting. Sessions will be held in the Hotel Statler.

Workshop on Medical Writing: An innovation at this year's Annual Meeting will be this workshop dealing with actual preparation of clinical articles for publication in *The Journal* and other medical media. Dr. Jonathan Forman, Editor of *The Journal*, will be in charge.

Annual Banquet: Wednesday evening is reserved for this special event at the Hotel Statler. Dinner, music and dancing as well as appropriate entertainment is in store for members and their ladies. Tickets at a cost of \$7.50 each will be sold by mail in advance of the meeting and will be available at Registration Headquarters after the meeting opens. All members will receive a banquet ticket order blank and envelope with the Official Call for the meeting which is being mailed to each member.

Telephone Service: The Academy of Medicine of Cleveland will operate a local information booth in the lobby of the Cleveland Public Auditorium. Physicians should pass this booth frequently to see if their names are on the call board. Physicians wanting to be reached during the meeting should have calls made to Cedar 1-3500.

1956 ANNUAL MEETING

Ohio State Medical Association
Cleveland Public Auditorium
TUESDAY, APRIL 10

(All sessions at the Public Auditorium unless otherwise indicated.)

TIME	EVENT	PLACE
8:30 A.M.	REGISTRATION OPENS	Main Entrance Lobby
9:00 A.M.	OPENING OF SCIENTIFIC AND TECHNICAL EXHIBITS	Arena, Main Floor
10:00 to 11:00 A.M.	JOINT SESSION OF SECTION ON ANESTHESIOLOGY AND SECTION ON PEDIATRICS	Ballroom, North Wing Fourth Floor
10:00 to 11:00 A.M.	OHIO ACADEMY OF GENERAL PRACTICE	Clubroom B, North Wing Third Floor
10:00 to 11:00 A.M.	OHIO CHAPTER, AMERICAN COLLEGE OF CHEST PHYSICIANS	Clubroom A, North Wing Fourth Floor
11:00 to 11:30 A.M.	RECESS FOR TOUR OF EXHIBITS	Arena, Main Floor
11:30 A.M. to 12:30 P.M.	CONTINUATION OF MORNING MEETINGS	
2:00 to 3:00 P.M.	JOINT SESSION, SECTION ON GENERAL PRACTICE AND SECTION ON SURGERY	Ballroom, North Wing Fourth Floor
2:00 to 2:30 P.M.	SECTION ON NERVOUS AND MENTAL DISEASES	Room A, South Wing Second Floor
2:00 to 3:00 P.M.	SECTION ON OPHTHALMOLOGY	Clubroom A, North Wing Fourth Floor
2:00 to 3:00 P.M.	OHIO SOCIETY OF ANESTHESIOLOGISTS	Room B, South Wing Third Floor
2:00 to 4:00 P.M.	OHIO CHAPTER, AMERICAN ACADEMY OF PEDIATRICS	Clubroom B, North Wing Third Floor
2:00 to 4:00 P.M.	MEDICAL MOTION PICTURES	Clubroom C, North Wing Third Floor
3:00 to 3:30 P.M.	RECESS FOR TOUR OF EXHIBITS	Arena, Main Floor
3:30 to 5:00 P.M.	CONTINUATION OF AFTERNOON MEETINGS	
5:00 P.M.	HOUSE OF DELEGATES BUSINESS SESSION	Pine Room, Mezzanine Floor Hotel Statler
7:30 P.M.	COMPLIMENTARY DINNER FOR MEMBERS OF THE HOUSE OF DELEGATES	Euclid Ballroom Mezzanine Floor Hotel Statler

1956 ANNUAL MEETING

Ohio State Medical Association

Cleveland Public Auditorium

WEDNESDAY, APRIL 11

(All sessions at the Public Auditorium unless otherwise indicated.)

TIME	EVENT	PLACE
8:30 A.M.	REGISTRATION	Main Entrance Lobby
9:00 to 9:30 A.M.	TOUR OF EXHIBITS	Arena, Main Floor
9:30 A.M. to 12:00 Noon	JOINT SESSION OF SECTION ON NEUROLOGICAL SURGERY AND SECTION ON RADIOLOGY	Ballroom, North Wing Fourth Floor
9:30 to 11:00 A.M.	SECTION ON OBSTETRICS AND GYNECOLOGY	Clubroom B, North Wing Third Floor
9:30 to 11:00 A.M.	SECTION ON PHYSICAL MEDICINE	Clubroom A, North Wing Third Floor
9:30 to 11:50 A.M.	OHIO PSYCHIATRIC ASSOCIATION (Luncheon, 12:30 P. M., Hotel Statler)	Room A, South Wing Second Floor
10:00 A.M. to 12:00 Noon	MEDICAL MOTION PICTURES	Clubroom C, North Wing Third Floor
10:00 A.M. to 12:00 Noon	WORKSHOP ON MEDICAL WRITING	Room B, South Wing Third Floor
11:00 to 11:30 A.M.	RECESS FOR TOUR OF EXHIBITS	Arena, Main Floor
11:30 A.M. to 12:30 P.M.	CONTINUATION OF MORNING MEETINGS	
2:30 to 5:30 P.M.	CONTINUATION OF MEETING OF OHIO PSYCHIATRIC ASSOCIATION	Room A, South Wing Second Floor
2:00 to 3:00 P.M.	GENERAL SESSION "The Diagnosis and Early Treatment of Cerebrovascular Accidents," WILLIAM F. ASHE, M.D. Columbus "The Scope and Value of Radiological Diagnosis in Cerebral Vascular Accidents," DONALD L. McRAE, M.D. Montreal, Canada	Ballroom, North Wing Fourth Floor
3:00 to 3:30 P.M.	RECESS FOR TOUR OF EXHIBITS	Arena, Main Floor
3:30 to 5:00 P.M.	GENERAL SESSION "Psychologic Aspects of Rehabilitation" ALEXANDER P. ORFIRER, M.D. Cleveland "Rehabilitation of the Hemiplegic Patient," MORTON MARKS, M.D. New York, N.Y.	Ballroom, North Wing Fourth Floor
7:30 P.M.	ANNUAL BANQUET	Grand Ballroom Mezzanine Floor Hotel Statler

1956 ANNUAL MEETING

Ohio State Medical Association
Cleveland Public Auditorium
THURSDAY, APRIL 12

(All sessions at the Public Auditorium unless otherwise indicated.)

TIME	EVENT	PLACE
8:30 A.M.	REGISTRATION	Main Entrance Lobby
9:00 to 9:30 A.M.	TOUR OF EXHIBITS	Arena, Main Floor
10:00 to 11:00 A.M.	GENERAL SESSION Panel Presentation: "Treatment of the Common Forms of Arthritis"	Ballroom, North Wing Fourth Floor
11:00 to 11:30 A.M.	RECESS FOR TOUR OF EXHIBITS	Arena, Main Floor
11:30 A.M. to 12:30 P.M.	GENERAL SESSION "Where Do We Stand on Polio?" FREDERICK C. ROBBINS, M.D. Cleveland	Ballroom, North Wing Fourth Floor
1:00 P.M.	COMPLIMENTARY LUNCHEON FOR MEMBERS OF THE HOUSE OF DELEGATES AND FINAL BUSINESS SESSION	Ohio Room, Mezzanine Floor Hotel Statler
2:00 to 4:00 P.M.	MEDICAL MOTION PICTURES	Clubroom C, North Wing Third Floor
2:00 to 3:00 P.M.	SECTION ON INTERNAL MEDICINE	Ballroom, North Wing Fourth Floor
2:00 to 3:00 P.M.	SECTION ON OTORHINOLARYNGOLOGY	Clubroom B, North Wing Third Floor
2:00 to 3:00 P.M.	SECTION ON UROLOGY	Room A, South Wing Second Floor
3:00 to 3:30 P.M.	RECESS FOR TOUR OF EXHIBITS (Exhibits Close at 3:30 P.M.)	Arena, Main Floor
3:30 to 5:00 P.M.	CONTINUATION OF AFTERNOON MEETINGS	

TUESDAY, APRIL 10

8:30 A.M.

REGISTRATION OPENS

Main Entrance Lobby
Cleveland Public Auditorium

9:00 A.M.

**OPENING OF SCIENTIFIC AND TECHNICAL
EXHIBITS**

TUESDAY, APRIL 10

10:00 A.M.

**JOINT SESSION OF SECTION ON
ANESTHESIOLOGY AND SECTION
ON PEDIATRICS**

Ballroom, North Wing, Fourth Floor
Public Auditorium

Lloyd E. Larrick, M.D., Cincinnati...Co-Chairman
Geo. F. Patterson, M.D., Cincinnati...Co-Chairman

10:00 to 11:00

ASPHYXIA IN THE NEWBORN (Panel Discussion)

Moderator: Robert A. Hingson, M.D., Cleveland,
Professor of Anesthesia, Western Reserve
University School of Medicine

Members of Panel:

Allan C. Barnes, M.D., Cleveland, Professor
and Chairman of Obstetrics and Gynecology,
Western Reserve University School of Medicine

Thomas E. Shaffer, M.D., Columbus, Professor,
Department of Pediatrics, Ohio State
University College of Medicine

Benjamin H. Landing, M.D., Cincinnati, Assistant
Professor of Pathology and Pediatrics, University of Cincinnati College of Medicine

John P. Garvin, M.D., Columbus, Assistant
Professor of Surgery (Anesthesia), Ohio
State University College of Medicine

11:00 to 11:30

RECESS FOR TOUR OF EXHIBITS

11:30 to 12:30

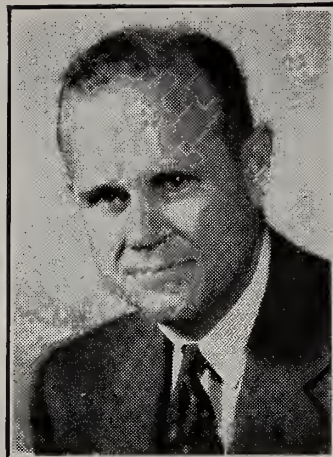
Continuation of panel discussion and question and
answer period

12:30 to 12:40

Business Meeting
Report of Nominating Committee
Election of Officers

**BE SURE TO VISIT EXHIBITS,
CLEVELAND PUBLIC AUDITORIUM**

Guest Speakers



JULIAN JOHNSON, M. D.
Philadelphia



CURTIS P. ARTZ
Lt. Col., MC, U.S. Army

TUESDAY, APRIL 10

10:00 A.M.

**ANNUAL MEETING OF OHIO CHAPTER
AMERICAN COLLEGE OF CHEST
PHYSICIANS**

Clubroom A, North Wing, Fourth Floor
Public Auditorium

H. S. Van Ordstrand, M. D., Cleveland...President
Francis G. Kravec, M. D., Youngstown...Secretary

10:00 to 10:30

**IS THE THORACIC LESION MALIGNANT—
SHOULD WE OPERATE?**

Julian Johnson, M. D., Philadelphia, Pa., Professor of Surgery, University of Pennsylvania School of Medicine

10:30 to 11:00

SOME PITFALLS IN THORACIC DIAGNOSIS

Bruce E. Douglass, M. D., Rochester, Minn., Section in Medicine (of Dr. Moersch) Mayo Clinic and Mayo Foundation

11:00 to 11:15

INTERMISSION

11:15 to 11:45

**SURGERY FOR CHRONIC PERICARDIAL EFFUSION:
BIOPSY AND PERICARDIAL WINDOW**

Donald B. Effer, M. D., Cleveland, Head of Department of Thoracic Surgery, Cleveland Clinic

11:45 to 12:15

**HIGH-SPEED PHOTOGRAPHY FOR
CARDIOANGIOGRAPHY DURING HEART
CATHETERIZATION**

(Film with Comments by the Speaker)

F. Mason Sones, Jr., M. D., Cleveland, Department of Cardiovascular Disease, Cleveland Clinic

12:15

Business Meeting

TUESDAY, APRIL 10

10:00 A.M.

OHIO ACADEMY OF GENERAL PRACTICE

Clubroom B, North Wing, Third Floor
Public Auditorium

10:00 to 10:30

SELECTION OF PATIENTS FOR HEART SURGERY

John J. Kralik, M.D., Garfield Heights, Director,
Cardiovascular Surgery, Marymount Hospital

10:30 to 11:00

**THE COMMONLY OVERLOOKED
INFECTIOUS DISEASES**

Samuel Saslaw, M.D., Ph.D., Columbus, Asso-
ciate Professor of Medicine and Bacteriology,
Ohio State University College of Medicine

11:00 to 11:30

RECESS FOR TOUR OF EXHIBITS

11:30 to 11:40

BUSINESS MEETING

11:40 to 12:30

RECENT TRENDS IN PEDIATRIC THERAPY

Robert D. Mercer, M.D., Cleveland, Head, De-
partment of Pediatrics, Cleveland Clinic

TUESDAY, APRIL 10

2:00 P.M.

**JOINT SESSION OF SECTION ON
GENERAL PRACTICE AND SECTION
ON SURGERY**

Ballroom, North Wing, Fourth Floor
Public Auditorium

F. A. McCammon, M.D., Van Wert ____ Co-Chairman
Stanley O. Hoerr, M.D., Cleveland ____ Co-Chairman

2:00 to 3:00

THE TREATMENT OF BURNS

Curtis P. Artz, M.D., San Antonio, Lt. Colonel,
MC, Director, Surgical Research Unit, Brooke
Army Medical Center, Fort Sam Houston,
Texas

Discussant: John H. Davis, M. D., Cleveland

3:00 to 3:30

RECESS FOR TOUR OF EXHIBITS

3:30 to 4:15

INJURIES OF THE CHEST

Julian Johnson, M.D., Philadelphia, Pa., Pro-
fessor of Surgery, University of Pennsyl-
vania School of Medicine and Graduate School
of Medicine

4:15 to 5:00

CHRONIC BACK PAIN

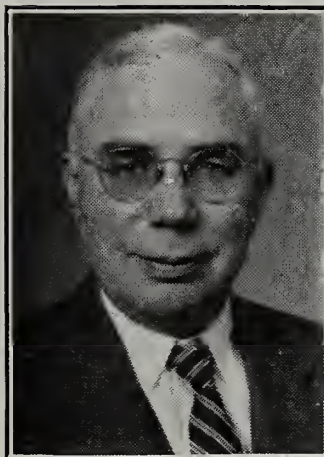
Carl E. Badgley, M.D., Ann Arbor, Mich., Pro-
fessor of Surgery and Chairman, Department
of Orthopedics, University of Michigan Medi-
cal School

5:00 to 5:10

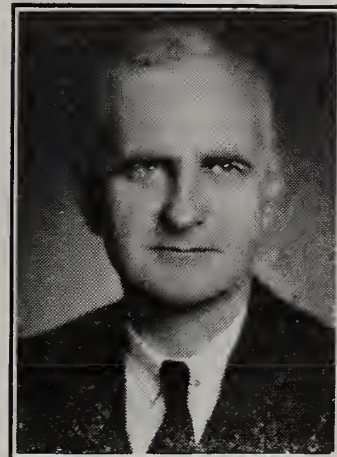
Business Meeting

Report of Nominating Committee
Election of Officers

Guest Speakers



CARL E. BADGLEY, M.D.
Ann Arbor, Mich.



D. E. CAMERON, M. D.
Montreal, Canada

TUESDAY, APRIL 10

2:00 P.M.

**SECTION ON NERVOUS AND MENTAL
DISEASES**

Room A, South Wing, Second Floor
Public Auditorium

Nicholas Michael, M.D., Columbus ____ Chairman
Herbert J. Weiss, M.D., Cleveland ____ Secretary

Theme: Trends in Neuropsychiatric Practice

2:00 to 2:15

**THE STATUS AND PROGRESS OF THE
RECEIVING HOSPITALS IN OHIO**

Eugene E. Elder, M.D., Youngstown, Superin-
tendent, Woodside Receiving Hospital

2:15 to 2:30

**THE RESEARCH AND TRAINING PROGRAM
AT THE COLUMBUS RECEIVING HOSPITAL
AND STATE PSYCHIATRIC INSTITUTE**

Ralph M. Patterson, M.D., Columbus, Superin-
tendent and Medical Director, Columbus Re-
ceiving Hospital; and Benjamin Pasamanick,
M.D., Columbus, Director of Research, Co-
lumbus Receiving Hospital

2:30 to 3:00

RECESS FOR TOUR OF EXHIBITS

3:00 to 4:00

STEPS IN PSYCHIC DRIVING THEORY

D. Ewen Cameron, M.D., Montreal, Canada,
Professor of Psychiatry and Chairman of
Department, McGill University

4:00 to 5:00

**PSYCHIATRIC UNITS IN GENERAL HOSPITALS
(Panel Discussion)**

Moderator: Howard D. Fabing, M.D., Cincinnati
Members of Panel: Calvin L. Baker, M.D.,
James B. Craig, M.D., and Leonard Ristine,
M.D., Columbus; Elmer Haynes, M.D., To-
ledo; James Sagebiel, M.D., Dayton

5:00 to 5:10

Business Meeting

Report of Nominating Committee
Election of Officers

TUESDAY, APRIL 10

2:00 P.M.

SECTION ON OPHTHALMOLOGY

Clubroom A, North Wing, Fourth Floor
Public Auditorium

Webb P. Chamberlain, Jr., M.D., Cleveland Chm.
E. J. Wenaas, M.D., Youngstown.....Secretary

Guest Speaker



HERMANN BURIAN, M. D.
Iowa City

2:00 to 3:00

**PROBLEMS IN DIAGNOSIS
AND TREATMENT OF
STRABISMUS**

Hermann M. Burian,
M. D., Iowa City,
Iowa, Professor of
Ophthalmology,
State University of
Iowa College of
Medicine

3:00 to 3:30

RECESS FOR TOUR OF EXHIBITS

3:30 to 5:00

**SURGICAL MANAGEMENT OF CATARACT WITH
GLAUCOMA (Panel Discussion)**

Moderator: E. J. Wenaas, M.D., Youngstown
Members of Panel: Ralph H. Miller, M.D., Cin-
cinnati; Roscoe J. Kennedy, M.D., Cleveland;
Claude S. Perry, M.D., Columbus; Thayer L.
Parry, M.D., Akron

5:00 to 5:10

Business Meeting
Report of Nominating Committee
Election of Officers

TUESDAY, APRIL 10

2:00 P.M.

OHIO SOCIETY OF ANESTHESIOLOGISTS

Room B, South Wing, Third Floor
Public Auditorium

A. William Friend, M.D., Akron.....President
R. M. Crane, M.D., Cleveland.....Secretary

2:00 to 2:20

**PRESENT-DAY USE OF OXYGEN THERAPY
IN THE PERI-ANESTHESIA PERIOD**

Kenneth Potter, M.D., Cleveland

2:20 to 2:30

DISCUSSION

2:30 to 2:50

**A SURVEY OF METHODS AND RESULTS IN THE
SIX-YEAR EXPERIENCE WITH THE CARDIAC
RESUSCITATION COURSE OF THE
CLEVELAND HEART SOCIETY**

Robert M. Hosler, M.D., Cleveland

2:50 to 3:00

DISCUSSION

3:00 to 3:30 P. M.

RECESS FOR TOUR OF EXHIBITS

3:30 to 3:50

**CIRCULATORY DISTURBANCES OF THE
PATIENT DURING ANESTHESIA**

Jay J. Jacoby, M.D., Columbus

3:50 to 4:00

DISCUSSION

4:00 to 4:20

**A RAPID METHOD OF INTUBATION IN CHILDREN
WITH SUBCUTANEOUS HYALURONIDASE AND
SUCCINYLCHOLINE FOLLOWING CYCLOPROPANE
INDUCTION OF ANESTHESIA**

James F. Hoffman, M.D., and Joseph K. Seale,
M.D., Cleveland

4:20 to 4:30

DISCUSSION

4:30 to 4:50

**A STUDY OF EXPERIENCES WITH INTRAVENOUS
PROCAINE AS AN ADJUVANT TO ANESTHESIA**

George F. Collins, M.D., Columbus

4:50 to 5:00

DISCUSSION

5:00 to 5:10

Election of Officers

TUESDAY, APRIL 10

2:00 P.M.

**OHIO CHAPTER, AMERICAN ACADEMY
OF PEDIATRICS**

Clubroom B, North Wing, Third Floor
Public Auditorium

Edward V. Turner, M. D., Columbus President
Robert H. Kotte, M. D., Cincinnati Secretary

2:00 to 4:00

**EMOTIONAL PROBLEMS OF ADOLESCENCE
(Round-table Discussion)**

Roswell Gallagher, M. D., Boston, Mass., Direc-
tor, Adolescent Unit, Children's Medical
Center

Benjamin Spock, M. D., Cleveland, Visiting Pro-
fessor of Child Development, Western Re-
serve University School of Medicine

Elizabeth Bremner, M. D., Cleveland, Assist-
ant Professor of Child Psychiatry, Western
Reserve University School of Medicine

4:00 to 5:00

Business Meeting

**BE SURE TO VISIT EXHIBITS,
CLEVELAND PUBLIC AUDITORIUM**

TUESDAY, APRIL 10

2:00 P. M.

MEDICAL MOTION PICTURES

Clubroom C, North Wing, Third Floor
Public Auditorium

2:00 to 2:28

"Anemia"

William Dameshek, M. D., Professor of Clinical
Medicine, Tufts College Medical School, Bos-
ton, Massachusetts

2:28 to 2:35

Intermission

2:35 to 3:05

"Congenital Malformations of the Heart—Part I"
Development of Normal Heart

Authors: R. F. Rushmer, M. D., and R. J. Blan-
dau, M. D., University of Washington, Seattle,
Washington

"Congenital Malformations of the Heart—Part II"
Acyanotic Congenital Heart Disease

Authors: R. F. Rushmer, M. D., and R. J. Blan-
dau, M. D.

3:05 to 3:14

Intermission

3:14 to 4:00

**"William Harvey: Discovery of Circulation of the
Blood"**

Produced by Royal College of Physicians (T.
Lewis and H. Dale)

**Telephone Service To Be Operated
By Cleveland Academy**

A telephone service for the Annual Meet-
ing will be operated by the Academy of
Medicine of Cleveland with a booth in the
main entrance of the Cleveland Public Audi-
torium. Every effort will be made to relay
messages to physicians attending the meet-
ing, but it has been found impractical to
page doctors in the meetings or on the
floor of the auditorium. Those anticipating
emergency calls should leave their names
and expected location at booth. All physi-
cians should pass the booth frequently to
see whether their names are on the call
board.

Each physician should leave with his
secretary the number of the Academy of
Medicine of Cleveland, CEdar 1-3500, as
well as the name of the hotel where he will
be staying. The Academy office will relay
emergency calls to the information booth
during the time programs are being con-
ducted in the Auditorium.

Physicians attending the House of Dele-
gates sessions and the Annual Banquet at
Hotel Statler may be contacted during
those meetings through the switchboard
of the hotel.

TUESDAY, APRIL 10

5:00 P.M.

HOUSE OF DELEGATES

**BUSINESS SESSION TO BE FOLLOWED BY
COMPLIMENTARY DINNER FOR DELEGATES,
OFFICERS AND COUNCILORS**

Pine Room, Mezzanine Floor, Hotel Statler

ORDER OF BUSINESS

Call to order by William J. Engel, M.D., Presi-
dent of the Cleveland Academy of Medicine.

Introduction of the President, Charles L. Hudson,
M.D., Cleveland.

Consideration of the minutes of the last Annual
Meeting (June, 1955, issue of *The Journal*.)

Appointment of Reference Committees by the
President:

- (a) Committee on Credentials of Delegates
- (b) Committee on President's Address
- (c) Committee on Resolutions
- (d) Committee on Tellers and Judges of
Election

Nomination and election of Committee on Nomi-
nations:

(Nominations from the floor. One representative
[delegate] from each Councilor District. The
committee shall report to the Second Session,
Thursday, 1:00 P.M., its recommendations in the
form of a ticket containing nominees for offices,
to be filled at this meeting, as required under the
Constitution and By-Laws.)

Introduction of Resolutions:

(Resolutions must be introduced at this session
of the House of Delegates, referred to the Ref-
erence Committee on Resolutions, and reported
back to the House of Delegates at the Thursday
afternoon session before any action can be taken.
All resolutions must be typewritten and sub-
mitted in triplicate.)

Announcements of meeting places of Committee
on Nominations and Reference Committees by
chairmen of the committees.

Miscellaneous business.

Announcements of Annual Meeting events.

Recess.

7:30 P.M.

Euclid Ballroom, Mezzanine Floor, Hotel Statler
Complimentary dinner for Delegates,
Officers and Councilors

**BE SURE TO VISIT EXHIBITS,
CLEVELAND PUBLIC AUDITORIUM**

WEDNESDAY, APRIL 11

8:30 A.M.

REGISTRATION

Main Entrance Lobby
Cleveland Public Auditorium

9:00 to 9:30

TOUR OF EXHIBITS

WEDNESDAY, APRIL 11

9:30 A.M.

**JOINT SESSION OF SECTION ON
NEUROLOGICAL SURGERY AND
SECTION ON RADIOLOGY**

Ballroom, North Wing, Fourth Floor
Public Auditorium

Frank H. Mayfield, M.D., Cincinnati Co-Chairman
Don D. Brannan, M.D., Cleveland Co-Chairman

9:30 to 9:50

**CORRELATION OF NEUROLOGICAL EXAMINATION,
MYELOGRAPHY AND OPERATIVE FINDINGS IN A
FIVE-YEAR SURVEY OF INTRASPINAL LESIONS**

George A. Nicoll, M.D., and Thomas A. Weaver,
M.D., Dayton

9:50 to 10:10

**VALUE OF MIDLINE TOMOGRAM FOR THE
DIAGNOSIS OF A THIRD VENTRICULAR
TUMOR—CASE REPORT**

Bert H. McBride, M.D., and Edward C. Elsey,
M.D., Cincinnati

10:10 to 10:30

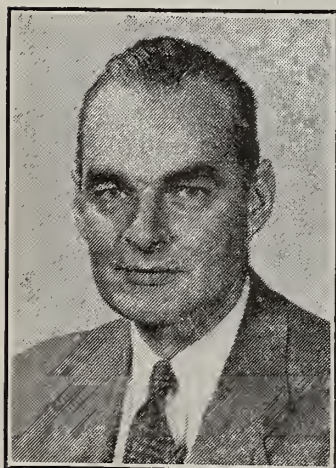
**CALCIFIED SUBDURAL HEMATOMAS
IN CHILDHOOD**

Jack Griffith, M.D., and Robert L. McLaurin,
M.D., Cincinnati

10:30 to 11:00

RECESS FOR TOUR OF EXHIBITS

Guest Speaker



DONALD L. McRAE, M.D.
Montreal, Canada

11:00 to 12:00

**THE SIGNIFICANCE OF
BONY ABNORMALITIES
ABOUT THE FORAMEN
MAGNUM**

Donald L. McRae,
M.D., Montreal,
Canada, Associate
Professor of Neuro-
radiology, Depart-
ment of Neurology
and Neurosurgery,
McGill University
Faculty of Medicine

12:00 to 12:30

**Business Meeting
Report of Nominating Committee
Election of Officers**

**INVITATION TO OB-GYN
PHYSICIANS**

Ohio specialists in obstetrics and gynecology who attend the Annual Meeting of the Ohio State Medical Association are invited to the regular meeting of the Cleveland Society of Obstetrics and Gynecology at the Cleveland University Club, 3813 Euclid Ave., on Monday, April 9. Cocktail hour begins at 6:30 p. m. followed by dinner. Cost is \$5.00 per person. Speaker will be Dr. William Kroger, Chicago. Arrangements should be made with Dr. Eduard Eichner, Secretary, 10605 Chester Ave., Cleveland 6.

WEDNESDAY, APRIL 11

9:30 A.M.

**SECTION ON OBSTETRICS AND
GYNECOLOGY**

Clubroom B, North Wing, Third Floor
Public Auditorium

Zeph J. R. Hollenbeck, M.D., Columbus Chairman
Rollis R. Miller, M.D., Youngstown Secretary

9:30 to 10:40

OFFICE GYNECOLOGY (Panel Discussion)

Moderator: James S. Krieger, M.D., Cleveland
Members of Panel: E. A. Riemenschneider,
M.D., Akron; P. K. Champion, M.D., Dayton;
Richard E. Boiman, M.D., Cincinnati; John
H. Holzaepfel, M.D., Columbus

10:40 to 11:00

**Business Meeting
Report of Nominating Committee
Election of Officers**

11:00 to 11:30

RECESS FOR TOUR OF EXHIBITS

11:30 to 12:40

**PREVENTABLE OBSTETRIC PROBLEMS
(Panel Discussion)**

Moderator: G. Keith Folger, M.D., Cleveland
Members of Panel: J. M. Gallen, M.D., Colum-
bus; Richard D. Bryant, M.D., Cincinnati;
R. K. Ramsayer, M.D., Canton; James H.
Williams, M.D., Columbus

JEFFERSON ALUMNI

Dr. Russell S. McGinnis, 10515 Carnegie Ave., Cleveland, is in charge of arrangements for the annual Jefferson Medical College Alumni dinner meeting. The event will begin with a cocktail hour at 7:00 p. m. in the Statler Hotel, on Tuesday, April 10.

WEDNESDAY, APRIL 11

9:30 A.M.

SECTION ON PHYSICAL MEDICINE

Clubroom A, North Wing, Third Floor
Public Auditorium

Harry T. Zankel, M.D., Cleveland.....Chairman
Keith C. Keeler, M.D., Akron.....Secretary

9:30 to 10:00

**ULTRASONIC TREATMENT—INDICATIONS,
CONTRAINDICATIONS AND DANGERS**

Justus F. Lehmann, M.D., Columbus, Assistant
Professor, Department of Physical Medicine
and Rehabilitation, Ohio State University

10:00 to 10:30

**SYNDROMES RELATED TO COMPRESSION
AT CERVICO-DORSAL OUTLET**

Paul A. Nelson, M.D., Cleveland, Head, De-
partment of Physical Medicine and Rehabili-
tation, Cleveland Clinic

10:30 to 11:00

PREVENTION OF DEFORMITY IN POLIOMYELITIS

Nadene Coyne, M.D., Cleveland, Director, De-
partment of Physical Medicine and Rehabili-
tation, City Hospital

11:00 to 11:30

RECESS FOR TOUR OF EXHIBITS

11:30 to 12:00

MANAGEMENT OF THE PARAPLEGIC CHILD

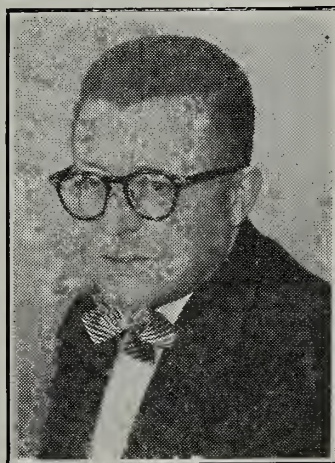
Mary L. Robb, M.D., C.M., Cleveland, Assistant
Physiatrist, Department of Physical Medi-
cine and Rehabilitation, Highland View Hos-
pital

Guest Speaker

12:00 to 12:30

**RECENT ADVANCES IN
THE DIAGNOSIS AND
TREATMENT OF
NEUROLOGICAL
DISEASES**

Morton Marks, M. D.,
New York, N. Y.,
Consultant in Neu-
rology, Institute of
Physical Medicine
and Rehabilitation,
New York Univer-
sity, Bellevue Medi-
cal Center



MORTON MARKS, M. D.
New York

12:30 to 12:40

**Business Meeting
Report of Nominating Committee
Election of Officers**

**BE SURE TO VISIT EXHIBITS,
CLEVELAND PUBLIC AUDITORIUM**

**Eight Hours of Credit Authorized
For General Practitioners**

Ohio Academy of General Practice Edu-
cation Committee has authorized eight
hours of Category II credit for members of
the Academy who avail themselves of the
postgraduate courses offered in the program
of the OSMA 1956 Annual Meeting.

WEDNESDAY, APRIL 11

9:30 A.M.

OHIO PSYCHIATRIC ASSOCIATION

Room A, South Wing, Second Floor
Public Auditorium

Nicholas Michael, M.D., Columbus.....President
Herbert J. Weiss, M.D., Cleveland.....Secretary

9:30 to 9:50

**GROUP PSYCHOTHERAPY WITH ALCOHOLICS
IN A STATE HOSPITAL**

Burman H. Preston, M.D., Cincinnati

9:50 to 10:00

DISCUSSION

10:00 to 10:20

PASSPORTS TO PSYCHOTHERAPY

Milton M. Parker, M.D., Ph.D., and Henry
Samuels, Ph.D., Columbus (by invitation)

10:20 to 10:30

DISCUSSION

10:30 to 10:45

RECESS FOR TOUR OF EXHIBITS

10:45 to 11:05

**INTENSIVE PSYCHOTHERAPY WITH
A DEAF PATIENT**

J. M. Wittenbrook, M.D., Cleveland

11:05 to 11:15

DISCUSSION

11:15 to 11:35

**THE MUTUAL RESPECT APPROACH TO CHILD
GUIDANCE AND ADULT PSYCHOTHERAPY**

W. Hugh Missildine, M.D., Columbus

11:35 to 11:50

DISCUSSION

11:50

ADJOURNMENT

12:30 to 2:00

LUNCHEON, OHIO ROOM, HOTEL STATLER

Speaker: Daniel Blain, M.D., Washington, D.C.,
Medical Director, American Psychiatric As-
sociation

2:00 to 2:30

BUSINESS MEETING

**SCIENTIFIC SECTION RESUMES,
CLEVELAND AUDITORIUM**

2:30 to 2:50

**NATURE OF DEGENERATIVE CHANGES SEEN
IN NERVE CELLS IN PSYCHOSES**

James W. Papez, M.D., Columbus

2:50 to 3:00

DISCUSSION

3:00 to 3:20

**MASKED EPILEPSY AS A PSYCHIATRIC
SYMPTOM COMPLEX**

Donn L. Tippet, M.D., and Irving Pine, M.D.,
Columbus

3:20 to 3:30

DISCUSSION

3:30 to 3:50

THE NEUROANATOMY OF MENTATION

William E. Hunt, M.D., Columbus

3:50 to 4:00

DISCUSSION

4:00 to 4:20

**REPORT OF EXPERIENCES WITH RITALIN
IN PSYCHOTIC PATIENTS**

Benjamin Kovitz, M.D., Columbus

4:20 to 4:30

DISCUSSION

4:30 to 5:30

**NEWER ASPECTS OF PSYCHOSOMATIC
MEDICINE**

Louis Schwartz, M.D., Detroit, Mich., Visiting
Professor from the University of Michigan
in Psychosomatic Diseases, and Chairman of
the Section of Neurology and Psychiatry

WEDNESDAY, APRIL 11

10:00 A.M.

MEDICAL MOTION PICTURES

Clubroom C, North Wing, Third Floor
Public Auditorium

10:00 to 10:28

"Anemia"

William Dameshek, M.D., Professor of Clinical
Medicine, Tufts College Medical School, Bos-
ton, Massachusetts

10:28 to 10:35

Intermission

10:35 to 11:05

**"Congenital Malformations of the Heart—Part I"
Development of Normal Heart**

Authors: R. F. Rushmer, M.D., and R. J. Blan-
dau, M.D., University of Washington, Seattle,
Washington

**"Congenital Malformations of the Heart—Part II"
Acyanotic Congenital Heart Disease**

Authors: R. F. Rushmer, M.D., and R. J. Blan-
dau, M.D.

11:05 to 11:14 A.M.

Intermission

11:14 to 12:00

**"William Harvey: Discovery of Circulation of the
Blood"**

Produced by Royal College of Physicians (T.
Lewis and H. Dale)

WEDNESDAY, APRIL 11

10:00 A.M.

WORKSHOP ON MEDICAL WRITING

Room B, South Wing

Third Floor

Public Auditorium

Conducted by Jonathan Forman, M.D., Co-
lumbus, Editor, *The Ohio State Medical Journal*;
and Chairman, Advisory Committee to the Amer-
ican Medical Writers' Association.

All Annual Meeting registrants are invited.
There will be a brief discussion of the purpose of
a paper; collecting material; picking the title;
drafting the outline; verification of references
and statistics; formulating the summary and con-
clusions. Following, there will be a dissection of
a paper and questions and answers.

WEDNESDAY, APRIL 11

2:00 P.M.

GENERAL SESSION

Ballroom, North Wing, Fourth Floor

Public Auditorium

Presiding: A. Carlton Ernstene, M.D., Cleveland,
Chairman, Committee on Scientific Work

2:00 to 2:30

**THE DIAGNOSIS AND EARLY TREATMENT
OF CEREBRAL VASCULAR ACCIDENTS**

William F. Ashe, M.D., Columbus

2:30 to 3:00

**THE SCOPE AND VALUE OF RADIOLOGICAL
DIAGNOSIS IN CEREBRAL VASCULAR ACCIDENTS**

Donald L. McRae, M.D., Montreal, Canada, As-
sociate Professor of Neuroradiology, Depart-
ment of Neurology and Neurosurgery, Mc-
Gill University Faculty of Medicine

3:00 to 3:30

RECESS FOR TOUR OF EXHIBITS

3:30 to 4:00

PSYCHOLOGIC ASPECTS OF REHABILITATION

Alexander P. Orfirer, M.D., Cleveland

4:00 to 5:00

REHABILITATION OF THE HEMIPLEGIC PATIENT

Morton Marks, M.D., New York, N.Y., Consult-
ant in Neurology, Institute of Physical Medi-
cine and Rehabilitation, New York University,
Bellevue Medical Center

WEDNESDAY, APRIL 11

7:30 P.M.

ANNUAL BANQUET

Grand Ballroom, Mezzanine Floor
Hotel Statler

Introduction of Officers, Councilors and Distinguished Guests.

Floor Show.

Dancing.

Tickets at \$7.50 each may be purchased by mail from the Columbus Office of the OSMA and at the Registration Headquarters after the meeting opens.



THURSDAY, APRIL 12

8:30 A.M.

REGISTRATION

Main Entrance Lobby
Cleveland Public Auditorium

9:00 to 9:30

TOUR OF EXHIBITS

THURSDAY, APRIL 12

10:00 A.M.

GENERAL SESSION

Ballroom, North Wing, Fourth Floor
Public Auditorium

Presiding: A. Carlton Ernstene, M.D., Cleveland,
Chairman, Committee on Scientific Work

10:00 to 11:00

**TREATMENT OF THE COMMON FORMS OF
ARTHRITIS (Panel Discussion)**

Moderator: Robert M. Stecher, M.D., Cleveland

Members of Panel: Nathan R. Abrams, M.D.,
Cincinnati; William S. Clark, M.D., and Ralph
Wolpaw, M.D., Cleveland; Roger Q. Davis,
M.D., Akron; and Norman O. Rothermich,
M.D., Columbus

11:00 to 11:30

RECESS FOR TOUR OF EXHIBITS

11:30 to 12:30

WHERE DO WE STAND ON POLIO?

Frederick C. Robbins, M.D., Cleveland

THURSDAY, APRIL 12

1:00 P.M.

HOUSE OF DELEGATES

**COMPLIMENTARY LUNCHEON
FOR MEMBERS OF THE HOUSE OF
DELEGATES TO BE FOLLOWED BY
THE FINAL BUSINESS SESSION**

Ohio Room, Mezzanine Floor
Hotel Statler

ORDER OF BUSINESS

Consideration of unfinished business from Tuesday's session of the House of Delegates.

Reports of Reference Committees:

(a) Committee on President's Address.

(b) Committee on Resolutions.

Election of President-Elect. Nominations from the floor.

Report of Committee on Nominations:

(a) Election of members of The Council.

(Members of The Council are elected for two-year terms; terms of those representing the odd-numbered districts expire in even-numbered years.) To be elected:

First District—(Incumbent, Charles T. Atkinson, M.D., Middletown.)

Third District—(Incumbent, James R. Jarvis, M.D., Van Wert.)

Fifth District—(Incumbent, George W. Petznick, M.D., Shaker Heights.)

Seventh District—(Incumbent, Robert E. Hopkins, M.D., Coshocton.)

Ninth District—(Incumbent, C. L. Pitcher, M.D., Portsmouth.)

Eleventh District—(Incumbent, H. T. Pease, M.D., Wadsworth.)

(b) Election of Delegates and Alternates to the American Medical Association—four Delegates and four Alternates to be elected, each for a two-year term starting January 1, 1957, in compliance with the Constitution and By-Laws of the American Medical Association.

The following incumbent Delegates and Alternates will serve for the remainder of 1956, their terms expiring December 31, 1956, and they may be considered by the nominating committee for two-year terms starting January 1, 1957:

Carl A. Lincke, M.D., Carrollton
(Delegate)

H. M. Platter, M.D., Columbus
(Alternate)

Wm. M. Skipp, M.D., Youngstown
(Delegate)

C. E. Hufford, M.D., Toledo
(Alternate)

George A. Woodhouse, M.D., Pleasant Hill
(Delegate)

R. Dean Dooley, M.D., Dayton
(Alternate)

Herbert B. Wright, M.D., Cleveland
(Delegate)

Fred W. Dixon, M.D., Cleveland
(Alternate)

Installation of officers for 1956-1957.

Submission of committee appointments by the new President for confirmation by the House of Delegates.

Unfinished or new business.

Adjournment.

THURSDAY, APRIL 12

2:00 P.M.

MEDICAL MOTION PICTURES

Clubroom C, North Wing, Third Floor

2:00 to 2:28

"Anemia"

William Dameshek, M.D., Professor of Clinical Medicine, Tufts College Medical School, Boston, Massachusetts

2:28 to 2:35

Intermission

2:35 to 3:05

**"Congenital Malformations of the Heart—Part I"
Development of Normal Heart**

Authors: R. F. Rushmer, M.D., and R. J. Blandau, M.D., University of Washington, Seattle, Washington

**"Congenital Malformations of the Heart—Part II"
Acyanotic Congenital Heart Disease**

Authors: R. F. Rushmer, M.D., and R. J. Blandau, M.D.

3:05 to 3:14

Intermission

3:14 to 4:00

"William Harvey: Discovery of Circulation of the Blood"

Produced by Royal College of Physicians (T. Lewis and H. Dale)

THURSDAY, APRIL 12

2:00 P.M.

SECTION ON INTERNAL MEDICINE

Ballroom, North Wing, Fourth Floor

Public Auditorium

H. Campbell Haynie, M.D., Columbus.....Chairman
J. Harold Kotte, M.D., Cincinnati.....Secretary

2:00 to 3:00

**DRUGS AFFECTING MOOD AND BEHAVIOR
(Panel Discussion)**

Moderator: Chauncey D. Leake, Ph.D., Columbus

Members of Panel: Howard D. Fabing, M.D., and J. Robert Hawkins, M.D., Cincinnati

3:00 to 3:30

RECESS FOR TOUR OF EXHIBITS

3:30 to 3:45

Business Meeting

Report of Nominating Committee

Election of Officers

3:45 to 5:00

CARDIAC SURGERY (Panel Discussion)

Moderator: R. W. Scott, M.D., Cleveland

Members of Panel: Walter Pritchard, M.D., George H. A. Clowes, Jr., M.D., and F. Mason Sones, Jr., M.D., Cleveland; Samuel Kaplan, M.D., Cincinnati; Joseph M. Ryan, M.D., and H. William Clatworthy, Jr., M.D., Columbus

THURSDAY, APRIL 12

2:00 P.M.

SECTION ON OTORHINOLARYNGOLOGY

Clubroom B, North Wing, Third Floor

Public Auditorium

Paul M. Moore, M.D., Cleveland.....Chairman
Robert E. Boswell, M.D., Dayton.....Secretary

2:00 to 3:00

LESSER FRACTURES OF THE FACE

Gerson Lowenthal, M.D., Cincinnati

3:00 to 3:30

RECESS FOR TOUR OF EXHIBITS

3:30 to 4:30

THE HEADACHE PROBLEM (Panel Discussion)

Moderator: H. C. Rosenberger, M.D., Cleveland

Members of Panel:

Raymond L. Hilsinger, M.D., Cincinnati, Attending Otolaryngologist, Cincinnati General Hospital

Leonard L. Lovshin, M.D., Cleveland, Department of Internal Medicine, Cleveland Clinic

David B. Roth, M.D., Dayton, Attending Neurosurgeon, Miami Valley, Good Samaritan and St. Elizabeth Hospitals

Wm. P. Garver, M.D., Cleveland, Chief of Allergy, St. Luke's, St. Vincent Charity and Cleveland City Hospitals

Thomas L. Edwards, M.D., Lima, Diplomate, American Board of Ophthalmology

4:30 to 4:45

QUESTION AND ANSWER PERIOD

4:45 to 5:00

Business Meeting

Report of Nominating Committee

Election of Officers

**OPHTHALMOLOGICAL CLUB
TO HOLD DINNER**

Members of the Ohio State Medical Association Eye Section are invited to the cocktail hour and dinner meeting of the Cleveland Ophthalmological Club, scheduled at the Wade Park Manor on Tuesday, April 10, beginning at 6:30 p.m. There will be a charge of \$7.50 per plate to cover cocktails and dinner. Reservations should be made with Dr. Webb P. Chamberlain, Jr., 1422 Euclid Ave., Cleveland 15, Ohio.

THURSDAY, APRIL 12

2:00 P.M.

SECTION ON UROLOGY

**Room A, South Wing, Second Floor
Public Auditorium**

Edward F. Ockuly, M.D., Toledo.....Chairman
Robert A. Keating, M.D., Columbus.....Secretary

Guest Speaker

2:00 to 3:00

**PROBLEMS INVOLVED IN
THE MANAGEMENT OF
BLADDER NECK
OBSTRUCTION IN
CHILDREN**

Edgar Burns, M. D.,
New Orleans, La.,
Professor and
Chairman, Depart-
ment of Urology,
Tulane University
of Louisiana School
of Medicine



EDGAR BURNS, M. D.
New Orleans

3:00 to 3:30

**COFFEE BREAK AND RECESS FOR
TOUR OF EXHIBITS**

3:30 to 4:30

PYELOGRAMS (Panel Discussion)

Moderator: Edgar Burns, M.D., New Orleans
Members of Panel: William J. Engel, M.D.,
Cleveland; William N. Taylor, M.D., Colum-
bus; Richard S. Graves, M.D., Dayton

4:30 to 5:00

**Business Meeting
Report of Nominating Committee
Election of Officers**

☆ ☆ ☆

MONDAY, APRIL 9

**ANNUAL MEETING
OHIO STATE HEART ASSOCIATION**

**Ohio Room, Mezzanine Floor
Hotel Statler**

1:45 P.M.

Scientific Session for Members of the Medical
Profession on Diseases of the Heart
Presiding: J. Lester Kobacker, M.D., Toledo

**BE SURE TO VISIT EXHIBITS,
CLEVELAND PUBLIC AUDITORIUM**

MONDAY (Cont'd)

1:45 to 3:10

**VASCULAR DISEASE IN THE MODERN
MEDICAL WORLD (Panel Discussion)**

Moderator: Geza de Takats, M.D., Chicago, Ill.,
Clinical Professor of Surgery, University of
Illinois College of Medicine

Post Phlebitic Syndrome
Geza de Takats, M.D.

Treatment of Vascular Occlusions
Alfred W. Humphries, M.D., Cleveland

Management of Acute Cerebral Accidents
Keith Sheldon, M.D., Cleveland

3:20 to 4:15

DIRECT VISION INTERCARDIAC SURGERY

Clarence W. Lillehei, M.D., Minneapolis, Minn.,
Associate Professor of Surgery, University
of Minnesota Medical School

PUBLIC HEALTH SESSION

**Pine Room, Mezzanine Floor
Hotel Statler**

1:45 to 4:15 P.M.

**HEART DISEASE—A COMMUNITY
RESPONSIBILITY**

Presiding: Donald L. Mahanna, M.D., Columbus

1:45 to 2:45

**THE CHILD WITH RHEUMATIC FEVER AND
RHEUMATIC HEART DISEASE**

Children's Diagnostic Centers
Robert A. Lyon, M.D., Cincinnati, Associate
Professor of Pediatrics, University of Cin-
cinnati College of Medicine

Services of the Crippled Children's Commission
Nathan P. Eisenberg, M.D., Columbus, Medi-
cal Director, Services for Crippled Chil-
dren, State of Ohio

2:55 to 4:15

**COMMUNITY EDUCATION AND HEART DISEASE—
A VISTA**

Moderator: Wesley Cushman, Ph.D., Columbus,
Department of Physical Education, Ohio
State University

Viewpoint of Medicine

A. D. Robertson, M.D., Ashland, Medical
Adviser, Ashland County Heart Associa-
tion

Viewpoint of Schools

W. K. Streit, Cincinnati, Director, Division
of Health and Hygiene, Cincinnati Pub-
lic Schools

Viewpoint of Heart Associations

M. Frederick Arkus, New York, Public Re-
lations Counsel, American Heart Asso-
ciation

Viewpoint of Health Department

Ralph E. Dwork, M.D., Columbus, Director
of Health, State of Ohio

Viewpoint of Newspaper

Don Dunham, Cleveland, Medical Writer,
Cleveland Press.

There are no charges or registration fees.

Workshop in Medical Writing . . .

This Feature of the 1956 Annual Meeting in Cleveland Will Be of Interest to All Physicians Who May Wish To Write for Publication

THIS year at the Annual Meeting of the Association in Cleveland there will be conducted a workshop on Medical Writing. This innovation of the State Medical Association will be under direction of Dr. Jonathan Forman, Editor of *The Journal*, with the aid of *The Journal* staff.

Dr. Forman is keenly interested in the subject of medical writing and has broad experience in that field. In addition to being Editor of *The Journal*, he is chairman of the Advisory Committee of the American Medical Writers' Association. He is also editor of *The Letters*, publication of the International Correspondence Society of Allergists; editor of the *Directory of Physicians Throughout the World Interested in Allergy*; editor of Bibliographic Section of the *Quarterly Review of Allergy and Allied Immunology*; editor of *Land & Water*, and contributing editor to *The Annals of Allergy*.

The seminar on medical writing will be held from 10:00 a.m. to noon on Wednesday, April 11, in the Cleveland Public Auditorium. All persons registered at the Annual Meeting are invited to attend and to take part.

The plan of operation calls for brief discussions on (1) the purpose of the medical paper, (2) its working title, (3) for what publication it is written, (4) the collection of material and making use of the library, etc., (5) arranging the material according to outline, (6) writing the paper, (7) correcting, condensing and re-writing, and (7) final corrections.

Following this discussion there will be a presentation of a clinical paper which has been subjected to the consulting service of the American Medical Writers' Association, after which there will be open discussion and answers to questions.

Last year Dr. Forman conducted the first workshop for the American College of Allergists and last Fall the American Medical Writers' Association presented its first workshop in connection with its annual meeting. Those two programs represent the first efforts to bring instruction in medical writing to physicians at their own meetings. Every effort is being made by members of the American Medical Writers' Association to interest other medical societies in scheduling medical writing workshops in an attempt to improve the writings of their members.

MUTUAL HELP

Dr. Forman pointed out that the American Medical Writers' Association was formed for

mutual help in the improvement of the art of communication among members of the medical profession. Medical editors are concerned with the inadequacy of all too many manuscripts that come to their desks. On the other hand, medical writers are anxious to learn the art of putting into words their thoughts, observations and conclusions so that they will be understood by the readers of medical literature.

Dr. Forman expressed his hope that this workshop might be only the first in a series which will make a worthwhile contribution to medical writing and to *The Ohio State Medical Journal*.

Ohio State Surgical Association To Meet in Cleveland, April 9

There will be a meeting of the Board of Directors of the Ohio State Surgical Association on Sunday, April 8, at 2:00 P. M. in Hotel Cleveland, Cleveland, and on Monday, April 9, the day before the Annual Meeting of the Ohio State Medical Association, the surgical association will hold its annual meeting in Cleveland. Following is a synopsis of the program scheduled for Monday, April 9:

9:00 to 10:30 A. M.—Business session. Club Room B, Cleveland Public Auditorium (for members only).

10:30 A. M. to 12:00 Noon. "Administrative Surgical Problems," Dr. Robert S. Myers, assistant director, American College of Surgeons.

12:30 to 2:00 P. M. Luncheon. Empire Room, Hotel Cleveland.

2:00 to 3:00 P. M. "Treatment of Carcinoma of Stomach From the Standpoint of the Lymphatic Spread," Dr. Gordon McNeer, Memorial Cancer Center, New York City. Club Room B, Cleveland Public Auditorium.

3:00 to 4:00 P. M. Panel discussion, "Chronic Venous Insufficiency." Club Room B, Cleveland Public Auditorium.

EENT Program in Roanoke

Gill Memorial Eye, Ear and Throat Hospital, 711 South Jefferson St., Roanoke, Va., has announced its 29th annual Spring congress in ophthalmology, otolaryngology and allied specialties. The dates are April 2-7. Physicians interested are invited to write to the Hospital for additional information.

DELEGATES AND ALTERNATES

Counties	Delegates	Alternates
FIRST DISTRICT		
ADAMS	S. J. Ellison	R. L. Woodyard
BROWN	W. L. Faul	George P. Tyler, Jr.
BUTLER	Walter A. Reese Neil Millikin	William U. Neel John F. Borelli
CLERMONT	Carl A. Minning	Albert O. Ryan, Jr.
CLINTON	Edmond K. Yantes	Thomas Faehnle
HAMILTON	Robert J. Anzinger Harry K. Hines Charles W. Hoyt J. Robert Hudson Daniel V. Jones J. Harold Kotte Robert D. Mansfield Elmer R. Maurer William A. Moore Virgil A. Plessinger Louis P. Stickley	Henry C. Beekley Joseph J. Bell F. Paul Duffy Virginia M. Esselborn Roy L. Kile Edgar S. Lotspeich Howard F. Pfister Stuart A. Schloss Harry C. Shirkey William C. Thornell Edward Woliver
HIGHLAND	J. Martin Byers	John G. Anderson
WARREN	O. L. Layman	Howard G. Berninger

SECOND DISTRICT		
CHAMPAIGN	Isador Miller	V. R. Frederick
CLARK	J. Harold Shanklin Ray M. Turner	William H. Crays E. W. Schilke
DARKE	Maurice M. Kane	P. H. Mulder
GREENE	Paul D. Espey	C. G. McPherson
MIAMI	Dale A. Hudson	W. W. Trostel
MONTGOMERY	R. D. Dooley H. M. James T. L. Light R. E. Pumphrey Ned D. Shepard	Kenneth D. Arn L. E. Baker R. M. Craig W. H. Hanning C. L. Kagay
PREBLE	C. J. Brian	A. L. Ross
SHELBY	Harry E. Crimm	John Kerrigan

THIRD DISTRICT		
ALLEN	Fred P. Berlin	Robert M. Johnson
AUGLAIZE	F. A. Hemsath C. W. Berry	C. E. Savage D. W. Nielsen
CRAWFORD	J. E. Loggins	T. D. Sawyer
HANCOCK	Harold K. Treece	Charles H. Evans
HARDIN	Floyd M. Elliott	Louis A. Black
LOGAN	H. L. Mikesell	D. W. Beach
MARION	M. S. Olson	Daniel M. Murphy
MERCER	Julius Schwieger	G. H. McIlroy
SENECA	Walter A. Daniel	Henry L. Abbott
VAN WERT	E. W. Burnes	A. C. Diller
WYANDOT	F. M. Smith	A. F. Murphy

FOURTH DISTRICT		
DEFIANCE	D. J. Slosser	J. U. Fauster, Jr.
FULTON	C. S. Kellogg	R. K. Vogel
HENRY	Thomas F. Tabler	E. C. Winzeler
LUCAS	C. L. Felker Warren A. Baird J. L. Kobacker F. F. A. Rawling Howard E. Smith G. H. Start G. A. Boon	Henry Burstein A. J. Kuehn E. F. Ockuly O. H. Stone R. P. Whitehead C. S. Wohl C. R. Wood
PAULDING	T. P. Fast	D. E. Farling
PUTNAM	Milo B. Rice	D. B. Lucas
SANDUSKY	A. C. Rini	R. R. Wilson
WILLIAMS	John R. Riesen	Paul G. Meckstroth
WOOD	Roger A. Peatee	Frederick F. Price

FIFTH DISTRICT		
ASHTABULA	S. A. Burroughs	R. C. Irving
CUYAHOGA	J. O. Barr F. L. Browning J. H. Budd A. C. Corcoran E. A. Ferreri H. A. Haller J. B. Hazard H. D. Iler C. R. Jablonoski F. R. Kelly G. R. Krause T. W. Knickerbocker M. H. Lambricht A. M. Leigh P. A. Mielcarek J. M. Rossen P. J. Schildt E. L. Smith	Eduard Eichner J. A. Gavin J. J. Grady F. J. Rack H. W. Salter G. L. Sackett E. W. Shannon K. W. Sheldon T. D. Kinney J. L. Bilton
GEAUGA	Dale J. Hawk	Walter C. Corey
LAKE	Benjamin S. Park	James G. Powell

Counties	Delegates	Alternates
SIXTH DISTRICT		
COLUMBIANA	John A. Fraser	Paul H. Beaver
MAHONING	M. W. Neidus Asher Randell Wm. M. Skipp	Hugh N. Bennett Paul J. Mahar Fred G. Schlecht
PORTAGE	David S. Palmstrom	Arthur L. Knight
STARK	John R. Seesholtz Robert E. Tschantz Jack L. Yahraus	A. E. Boyles Ian B. Hamilton Wm. A. White, Jr.
SUMMIT	A. William Friend Donald I. Minnig H. O. Musser Carl C. Nohe	Arthur Dobkin James F. Lemmon A. H. Kyriakides M. R. Werner
TRUMBULL	E. G. Caskey E. R. Westbrook	Joseph Gledhill Aubrey Sparks

SEVENTH DISTRICT		
BELMONT	B. C. Diefenbach	A. J. Antalis
CARROLL	J. D. Stires	Carl A. Lincke
COSHOCTON	G. A. Foster	Floyd W. Craig
HARRISON	G. E. Henderson	
JEFFERSON	Carl F. Goll	Warren G. Snyder
MONROE	Byron Gillespie	
TUSCARAWAS	J. W. Hamilton	R. E. Rinderknecht

EIGHTH DISTRICT		
ATHENS	E. A. Sprague	John Greenlees
FAIRFIELD	C. P. Swett	Jack L. Kraker
GUERNSEY	James A. L. Toland	Robert A. Ringer
LICKING	R. G. Plummer	J. Fleek Miller
MORGAN	Henry Bachman	A. A. Coulson
MUSKINGUM	A. C. Ormond	J. Herbert Bain
NOBLE	E. G. Ditch	C. F. Thompson
PERRY	C. B. McDougal	James Miller
WASHINGTON	K. E. Bennett	Ford E. Eddy

NINTH DISTRICT		
GALLIA	L. L. Brown	R. B. Burner
HOCKING	C. T. Grattidge	H. M. Boocks
JACKSON	A. R. Hambrick	C. C. Fitzpatrick
LAWRENCE	George N. Spears	John A. Dole, Jr.
MEIGS	Roger P. Daniels	
PIKE	Mack E. Moore	S. M. Strain
SCIOTO	O. D. Tatje	Wm. M. Singleton
VINTON	H. D. Chamberlain	

TENTH DISTRICT		
DELAWARE	Robert S. Caulkins, Jr.	A. R. Callender
FAYETTE		
FRANKLIN	Perry R. Ayres George J. Hamwi Warren G. Harding Robert M. Inglis Charles W. Pavey Martin P. Sayers Judson D. Wilson	William F. Bradley John E. Martin Charles W. Matthews Jack W. Miles Clark P. Pritchett Samuel W. Robinson Anthony Ruppertsberg R. S. Lord J. W. Hurt
KNOX	Henry T. Lapp	
MADISON	Sol Maggied	
MORROW		
PICKAWAY	Robert G. Smith	J. M. Hedges
ROSS	Ralph W. Holmes	Robert E. Swank
UNION	E. J. Marsh	B. E. Ingmire

ELEVENTH DISTRICT		
ASHLAND	M. D. Shilling	H. W. Wetzel
ERIE	E. J. Meckstroth	George A. Stimson
HOLMES	N. P. Stauffer	A. J. Earney
HURON	O. J. Nicholson	J. V. Emery
LORAIN	Ben V. Myers G. R. Wiseman	A. L. Berman
MEDINA	R. F. Fasoli	Nevin J. M. Klotz
RICHLAND	Russell H. Barnes H. G. Knierim	C. O. Butner D. W. Dewald
WAYNE	A. B. Huff	Adrian J. Hartzler

OFFICERS		
Pres.	Charles L. Hudson	
Past-Pres.	M. D. Prugh	Treas. R. L. Meiling

COUNCILORS	
District	District
First.....Charles T. Atkinson	Seventh... Robert E. Hopkins
Second.....G. A. Woodhouse	Eighth..... Robert S. Martin
Third..... James R. Jarvis	Ninth..... C. L. Pitcher
Fourth..... Paul F. Orr	Tenth..... E. H. Artman
Fifth..... George W. Petznick	Eleventh..... H. T. Pease
Sixth..... Carl A. Gustafson	

SCIENTIFIC AND EDUCATIONAL EXHIBITS

The Scientific and Educational Exhibits in the Arena, Main Floor, Cleveland Public Auditorium, will be open daily from 9:00 A. M. to 5:30 P. M. on Tuesday, April 10, and Wednesday, April 11; and from 9:00 A. M. to 3:30 P. M. on Thursday, April 12.

A NEW FRONTIER IN PRIVATE PRACTICE

A. Clair Siddall, M. D., Oberlin.

LUMBAR DISK PROTRUSION

A. S. Tucker, M. D., and W. J. Gardner, M. D., Cleveland Clinic.

OPPORTUNITIES IN THE U. S. PUBLIC HEALTH SERVICE

Public Health Service, Chicago, Ill.

STUDIES IN PALLESTHESIS: VIBRATORY SENSE LEVELS IN DERMATOLOGY

Samuel Goldblatt, M. D., Cincinnati.

REVERSIBLE HYPERTENSION DUE TO RENAL ARTERY DISEASE

E. F. Poutasse, M. D., William J. Engel, M. D., and Harriet P. Dustan, M. D., Cleveland Clinic.

SPOT DIAGNOSIS OF ANTERIOR SEGMENT PATHOLOGY

Ira A. Abrahamson, Jr., M. D., and Ira A. Abrahamson, Sr., M. D., Cincinnati.

THE HOUSE OF HOPE

The Ohio Society for Crippled Children, Columbus.

HELP FOR THE CHILDLESS

Planned Parenthood League of Ohio, Columbus.

OPERATIONS FOR CORONARY ARTERY DISEASE

Claude S. Beck, M. D., Bernard L. Brofman, M. D., and David S. Leighninger, M. D., University Hospitals, Cleveland.

STRUMA LYMPHOMATOSA—PRIMARY THYROID FAILURE WITH COMPENSATORY THYROID ENLARGEMENT

Penn G. Skillern, M. D., Cleveland Clinic.

DISASTER—or—CATASTROPHE

Stephen S. Hudack, M. D., St. Luke's Hospital, Cleveland.

SPECIAL CARDIOPULMONARY TECHNIQUES: TEMPORARY UNILATERAL PULMONARY ARTERY OCCLUSION AND INTRACARDIAC ANGIOGRAPHY

Bernard L. Brofman, M. D., Bernard L. Charms, M. D., and John C. Elder, M. D., Cleveland.

ROUTINE OPERATIVE CHOLANGIOGRAPHY

Maurice D. Sachs, M. D., and Philip F. Partington, M. D., Cleveland.

PLASTIC EMBEDDED HEARTS: CLEARED AND CORRODED SPECIMENS

Kenneth Wolfe, B. S., University Hospitals, Cleveland.

YOUR HEART ASSOCIATION SERVES THE PHYSICIAN

Ohio State Heart Association, Columbus.

TEAMWORK IN HEALTH PROTECTION

Ohio State Pharmaceutical Association, Columbus.

LESIONS WITH CHRONIC SYMPTOMS PRODUCING PYLORIC OBSTRUCTION AND GASTRIC DECOMPENSATION. BENIGN OR MALIGNANT?

Arnold D. Piatt, M. D., and Gerald A. Erhard, M. D., Newark.

COMMON ORTHOPEDIC PROBLEMS IN CHILDREN

Barry A. Friedman, M. D., and Earl E. Smith, M. D., Mt. Sinai Hospital, Cleveland.

ORCHIDOFUNICOLYSIS

Victor C. Laughlin, M. D., Huron Road Hospital, Cleveland.

NEW HYDROTHERAPEUTIC TANK

Ralph E. Worden, M. D., and Mr. James A. Patterson, Children's Hospital, Columbus.

DIFFERENTIAL DIAGNOSIS—PULMONARY DISEASE

Ohio Tuberculosis & Health Association, Columbus.

SYNOVIAL AND FAT PAD—CHANGES OF THE KNEE JOINT

Maurice D. Sachs, M. D., Wilbert H. McGaw, M. D., Alfred C. Buegler, M. D., Russell P. Rizzo, M. D., G. Furey, M. D., P. Berg, M. D., Veterans Administration Hospital, Cleveland.

ANALYSIS OF RESULTS OF ARTERIAL GRAFTING

Alfred W. Humphries, M. D., Victor G. deWolfe, M. D., Fay A. LeFevre, M. D., Cleveland Clinic.

PORTA CAVAL SHUNT

John Storer, M. D., Huron Road Hospital, Cleveland.

TECHNIQUE OF VENIPUNCTURE IN INFANTS

Henry F. Saunders, M. D., Felino V. Barnes, M. D., Richard A. Bloomfield, M. D., Mt. Sinai Hospital, Cleveland.

CARDIAC EFFECTS OF ATHLETIC WORK STRESS

John W. Wilce, M. D., Ohio State University, Columbus.

HYPOGONADISM IN THE MALE

Arthur A. Roth, M. D., City Hospital, Cleveland.

OHIO CANCER REGISTRY

Ohio Cancer Coordinating Committee, Columbus.

CORNEAL TRANSPLANTATION

Department of Ophthalmology, Ohio State University College of Medicine.

PREMENSTRUAL TENSION SYNDROME

Eduard Eichner, M. D., Mt. Sinai Hospital, Cleveland.

THE ARTIFICIAL DIALYZER

Walter A. Keitzer, M. D., and Manley L. Ford, M. D., City Hospital, Akron.

PREVENTION OF CARDIAC ARREST

B. B. Sankey, M. D., and P. D. Sloan, M. D., St. Luke's Hospital, Cleveland.

VARIATIONS IN INITIAL X-RAY FINDINGS OF BRONCHOGENIC CARCINOMA

John D. Osmond, Jr., M. D., Cleveland.

CEREBRAL ANGIOGRAPHY IN CEREBRAL LOCALIZATION

Harry W. Slade, M. D., Simon Speniarian, M. D., Western Reserve University School of Medicine.

SITES OF METASTASES OF UTERINE CARCINOMA

John H. Holzaepfel, M. D., and Harry E. Ezell, M. D., Ohio State University College of Medicine.

OUTPATIENT TREATMENT FOR TUBERCULOSIS

Cuyahoga County Tuberculosis Clinic, Cleveland.

MULTIPLE MYELOMA (PLASMOCYTOMA)

James S. Hewlett, M. D., and John D. Battle, Jr., M. D., Cleveland Clinic.

THE RELATIONSHIP BETWEEN HUMAN SMOKING HABITS AND DEATH RATES

Ohio Division, American Cancer Society, Inc., Cleveland.

EIGHT YEARS EXPERIENCE WITH PULMONARY BIOPSY

Neil C. Andrews, M. D., and Karl P. Klassen, M. D., Ohio State University College of Medicine.

OPERATIVE CHOLANGIOGRAPHY

Chester R. Jablonoski, M. D., Marymount Hospital, Cleveland.

THE ULCEROGENIC TUMOR OF THE PANCREAS

Edwin H. Ellison, M. D., Ohio State University College of Medicine.

TECHNIQUES IN INTRACARDIAC SURGERY

Earle B. Kay, M. D., Frederick S. Cross, M. D., St. Luke's Hospital, Cleveland.

AN EXFOLIATIVE CYTOLOGY LABORATORY IN A GENERAL HOSPITAL

Edward E. Siegler, M. D., St. Luke's Hospital, Cleveland.

ABLE TO LIVE AGAIN

Bruno F. Gebhard, M. D., Mieczyslaw Peszczynski, M. D., and Nadene Coyne, M. D., Cleveland.

TECHNIQUES IN MEDICAL ILLUSTRATION

Fred Shepard, Ohio State University.

THE USE OF CUTIS AS AN INTERPOSING MEMBRANE IN ARTHROPLASTY OF THE KNEE

Joseph E. Brown, M. D., Wilbert H. McGaw, M. D., Darrel T. Shaw, M. D., St. Luke's Hospital, Cleveland.

APPLICATION OF PNEUMATIC AND HYDROSTATIC PRINCIPLES TO PATIENT CARE

W. James Gardner, M. D., and Donald F. Dohn, M. D., Cleveland Clinic.

Huron Road Hospital To Present Program, March 27 and 28

The Medical Staff of Huron Road Hospital is sponsoring a two-day postgraduate seminar in gastroenterology on Tuesday and Wednesday, March 27 and 28, where distinguished guest speakers and members of the Medical Staff will present material covering most of the recent developments in the field. The meeting will conclude with a banquet at the Wade Park Manor Hotel on Wednesday evening.

In addition to this dinner, luncheon will be served at Huron Road Hospital each day to those registered for the seminar. The daily sessions will be held in the Masonic Hall on Belmore Road, immediately adjacent to the hospital grounds. The parking facilities of the hall will be open for these meetings.

Huron Road Hospital is located at the corner of Terrace and Belmore Roads.

Interns and residents are invited to attend the two daytime sessions and the luncheons without charge.

Details of the program may be obtained from the staff, Huron Road Hospital, 13951 Terrace Rd., Cleveland 12.

Cincinnati Area Women Physicians Meet with Attorneys' Group

The annual joint dinner meeting of the Cincinnati Women Lawyers Club and Branch 11 of the American Medical Women's Association was held on January 17, at the Queen City Club. Dr. Frank Cleveland, who is assistant professor of pathology and industrial health, and head of the Pathology Section of the Kettering Laboratories, University of Cincinnati Medical School, gave the group an interesting lecture on "Relations Between Doctors and Lawyers—Professional and Social."

As their part of the Girls' Week Activities, Branch 11 of the American Medical Women's Association, gave a tea on February 12, at the home of Dr. Esther Marting, to entertain high school girls interested in medical careers. Members of the local medical group gave short talks on their particular specialties. Among those asked to speak were: Drs. Esther Marting, radiology; Gail Englender, pediatrics; Helen Compton, industrial medicine; Emily Wright, obstetrics; Marjorie Grad, general practice; Mabel Gardner, surgery; and Roselyn Touff, public health.—Rose-lyn Touff, M. D.

TECHNICAL EXHIBITORS

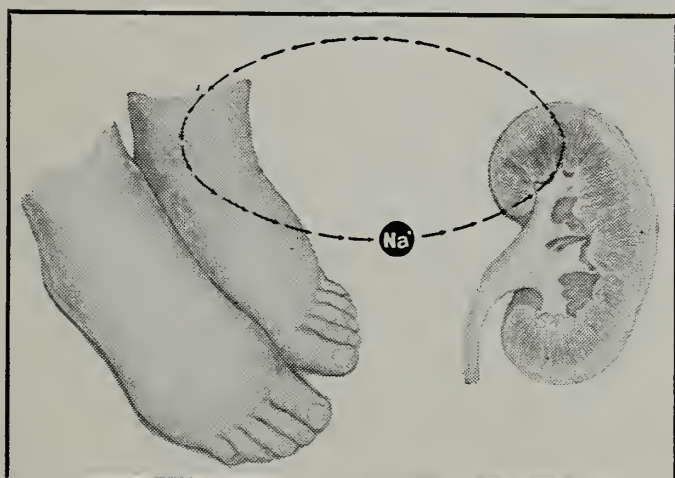
ARENA, MAIN FLOOR, CLEVELAND PUBLIC AUDITORIUM

Open from 9:00 A.M. to 5:30 P.M. on Tuesday, April 10, Wednesday, April 11, and
from 9:00 A.M. until 3:30 P.M. on Thursday, April 12

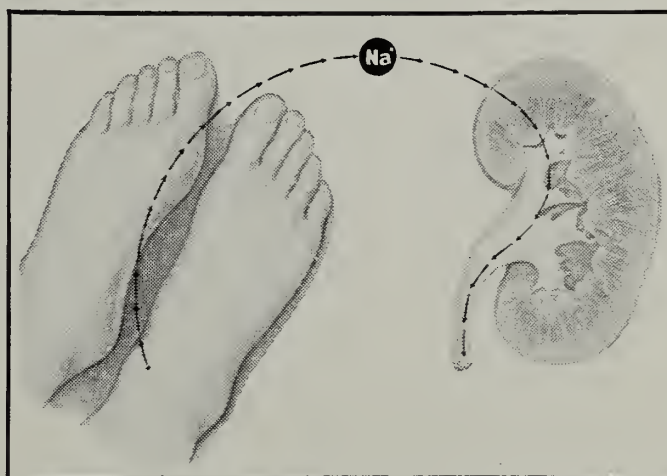
Exhibitor	Address	Booth No.	Exhibitor	Address	Booth No.
Abbott Laboratories, North Chicago, Ill.		33	Maico Company, Inc., Columbus, Ohio		27
Aloe, A. S., Company, St. Louis, Mo.		47	Maltbie Laboratories Div., Belleville, N.J.		5
Ames Company, Inc., Elkhart, Ind.		72	Massachusetts Indemnity Insurance Co., Boston, Mass.		77
Audio-Digest Foundation, Glendale, Cal.		95	Massengill, S. E., Co., Bristol, Tenn.		1
Avery Engineering Company, Cleveland, O.		76	Mead Johnson & Company, Evansville, Ind.		21
Ayerst Laboratories, New York, N.Y.		39	Medco Products Co., Tulsa, Okla.		73
Baby Development Clinic, Chicago, Ill.		64	Medical Aids, Inc., Park Ridge, Ill.		91
Baker Laboratories, Inc., The, Cleveland, O.		29	Medical & Dental Business Bureau, Cleve- land, Ohio		80
Beech-Nut Packing Co., New York, N.Y.		3	Medical Protective Company, The, Fort Wayne, Ind.		87
Bowman Bros. Drug Co., The, Canton, Ohio	19-20		Merrell, Wm. S., Co., The, Cincinnati, Ohio		50
Burroughs Wellcome & Co. (U.S.A.) Inc., Tuckahoe, N.Y.		24	Miller Surgical Company, Chicago, Ill.		101
Caldwell & Bloor Co., The, Mansfield, O.	96-97		Mueller, V., & Co., Chicago, Ill.		57
Cameron Surgical Specialty Co., Chicago, Ill.		22	Nepera Chemical Co., Inc., Yonkers, N.Y.		55
Camp, S. H., & Company, Jackson, Mich.		52	Ohio Medical Indemnity, Inc., Columbus, O.		81
Ciba Pharmaceutical Products, Inc., Summit, N.J.		53	Ortho Pharmaceutical Corp., Raritan, N.J.		17
Coca-Cola Company, The, Atlanta, Ga.		84	Parke, Davis & Company, Detroit, Mich.		92
Columbus Hospital Supply Co., Columbus, O.	67-68		Pelton & Crane Co., The, Charlotte, N.C.		56
Columbus Pharmacal Co., The, Columbus, O.		30	Pet Milk Company, St. Louis, Mo.		98
Coreco Research Corp., New York, N.Y.		45	Pfizer Laboratories, Brooklyn, N.Y.		23
Davies, Rose & Co., Limited, Boston, Mass.		90	Picker X-Ray Corp., White Plains, N.Y.		43
Desitin Chemical Company, Providence, R.I.		66	Purdue Frederick Co., The, New York, N.Y.		7
Dietene Company, The, Minneapolis, Minn.		93	Riker Laboratories, Inc., Los Angeles, Cal.		15
Eaton Laboratories, Norwich, N.Y.		61	Robins, A. H., Company, Inc., Richmond, Va.		41
Elder, Paul B., Company, Bryan, Ohio		8	Roerig, J. B., and Company, Chicago, Ill.		102
Electro-Therapeutic Instrument Co., Chicago, Ill.		4	Ross Laboratories, Columbus, Ohio (Formerly M & R Laboratories)		37
Encyclopedia Americana, Grand Rapids, Mich.		89	Sanborn Company, Cambridge, Mass.		38
Endo Products, Inc., Richmond Hill, N.Y.		2	Sandoz Pharmaceuticals, Hanover, N.J.		46
Fischer, H. G., & Co., Franklin Park, Ill.		54	Saunders, W. B., Company, Philadelphia, Pa.		14
Fleet, C. B., Company, Inc., Lynchburg, Va.		59	Schering Corporation, Bloomfield, N.J.		9
Foot-So-Port Shoes, Mansfield, Ohio		62	Schmid, Julius, Inc., New York, N.Y.		78
Fougera, E., & Co., Inc., New York, N.Y.		18	Schuemann-Jones Co., The, Cleveland, Ohio	74-75	
Freeman Manufacturing Co., Sturgis, Mich.		40	Sealy Mattress Company, Cleveland, Ohio		16
Gallagher-Roach & Company, Columbus, O.		48	Searle, G. D., & Co., Chicago, Ill.		60
General Electric Company, X-Ray Department, Milwaukee, Wis.		31-32	Sharp & Dohme, Inc., Philadelphia, Pa.		103
General Foods Corp., White Plains, N.Y.	70-71		Smith, Carroll Dunham Pharmacal Company, New Brunswick, N.J.		65
Hausted Manufacturing Company, Medina, O.		79	Smith, Kline & French Laboratories, Philadelphia, Pa.		51
Heinz, H. J., Company, Pittsburgh, Pa.		28	Squibb, E. R., & Sons, Division of Olin Mathieson Chemical Corp., New York, N.Y.		63
Hoffmann-La Roche Inc., Nutley, N.J.		83	Stuart Company, The, Chicago, Ill.		10
Holland-Rantos Co., Inc., New York, N.Y.		49	Testagar & Co., Inc., Detroit, Mich.		42
Hutton, W. E., & Company, Cincinnati, Ohio		82	Tutag, S. J., & Co., Detroit, Mich.		99
Kellogg Company, Battle Creek, Mich.		88	U. S. Standard Products, Mount Prospect, Ill.		6
Kremers-Urban Company, Milwaukee, Wis.	100		U. S. Vitamin Corporation, New York, N.Y.		36
Lederle Laboratories Division, American Cyanamid Co., Pearl River, N.Y.		44	Upjohn Company, The, Kalamazoo, Mich.		12
Liebel-Flarsheim Co., The, Cincinnati, O.		25	Warren-Teed Products Co., The, Columbus, O.		34
Lilly, Eli, and Company, Indianapolis, Ind.		13	Wendt-Bristol Co., Columbus, O.		11
Lippincott, J. B., Company, Philadelphia, Pa.		35	Winthrop Laboratories, Inc., New York, N.Y.		58
Lloyd Bros., Inc., Cincinnati, Ohio		69	Woche, Max & Son Co., The, Cincinnati, O.		26
Loma Linda Food Company, Arlington, Cal.		94			

New Orally Effective Diuretic for Congestive Edema

Best results are obtained when Mictine is administered with meals on an interrupted dosage schedule.



WITHOUT MICTINE—Prior to diuretic therapy excessive sodium and water are characteristically retained in the edematous patient.



WITH MICTINE—Inhibition of the reabsorption of sodium ion leads to an increased excretion of sodium ion, water and chloride.

An effective diuretic has been described as one which causes excretion of water, sodium and chloride in amounts sufficient to reduce the edema but not to result in salt depletion.

Mictine (brand of aminometradine) introduces to clinical practice an *improved* diuretic which not only meets the standard qualifications but has these seven additional advantages:

Mictine is orally effective; it is not a mercurial; it has no known contraindications; it does not upset the acid-base balance; it exerts no significant influence on electrolyte balance; it may be given in the presence of renal or hepatic diseases; it is well tolerated.

As with most effective therapeutic agents, in high dosage Mictine may cause some side effects in some patients; however, on three tablets daily side effects (anorexia and nausea, rarely vomiting,

*Trademark of G. D. Searle & Co.

diarrhea or headache) are minimal or absent.

Clinically, Mictine is useful in the maintenance of an edema-free state in all patients and for initial and continuing diuresis in mild or moderate congestive failure. It is not intended for initial diuresis in severe congestive failure unless either sensitivity or tolerance to other diuretics has developed in the patient.

The maintenance dosage of Mictine, as well as for initial diuresis in mild or moderate congestive heart failure, is one to four 200-mg. tablets daily in divided doses; the dosage for initial diuresis in severe congestive failure, under the conditions already described, is four to six tablets daily. For either use, it is recommended that Mictine be prescribed with meals on interrupted dosage schedules; that is, prescribing Mictine on alternate days or for three consecutive days and omitting it the next four days.

Descriptive literature and clinical trial packages are available on request to . . .

SEARLE

P. O. Box 5110, B
Chicago 80, Illinois

Woman's Auxiliary Annual Meeting . . .

To Be Held at Hotel Statler in Cleveland Same Week as OSMA Meeting;
Program and Special Events Arranged for All Doctors' Wives Who Attend

THE Annual Meeting of the Woman's Auxiliary to the Ohio State Medical Association will be held at the Hotel Statler in Cleveland on April 9, 10, 11, and 12, (Monday through Thursday) concurrently with the meeting of the Ohio State Medical Association.

The competent Cleveland committees, who are at work on details connected with the program, are headed by Mrs. C. A. Colombi, chairman, and Mrs. Charles A. Obert, co-chairman.

Included in their plans is the "Doctor's Day" luncheon on Wednesday—a good time to be enjoyed by both husbands and wives. The luncheon will honor doctors and will feature "The Lamplighters" for their special enjoyment. It is timed so that it will not conflict with any of the OSMA sessions.

The National Auxiliary President, Mrs. Mason G. Lawson of Little Rock, Arkansas, will be present at the meetings and will take part in the Thursday morning session. The Thursday luncheon, with its accompanying style show deluxe for all doctor's wives, will provide a fitting climax to the many attractions of this 1956 convention.

The tentative program is as follows:

MONDAY, APRIL 9

10:30 A. M.

Budget Committee meeting

2:30 P. M.

Pre-Convention Board Meeting

6:30 P. M.

Board of Directors Dinner

TUESDAY, APRIL 10

9:00 A. M.

Registration—Assembly Foyer—Mezzanine

10:30 A. M.

Resolutions Committee and Policy Committee meeting

2:00 P. M.

School of Instruction for County Presidents, Presidents-Elect, and District Directors

3:30 P. M.

Tea for all doctor's wives—Woman's City Club

7:00 P. M.

Gavel Club Dinner

WEDNESDAY, APRIL 11

8:30 A. M.

Registration—Assembly Foyer—Mezzanine

9:00 A. M.

Opening Business Session—Pine Room

Presiding—Mrs. Karl F. Ritter, President

Invocation

Pledge of Loyalty

Greetings

Address of Welcome

Response

Introduction of Convention Chairmen

Adoption of Rules of Convention

Report of Roll Call Chairman

Minutes of 1955 Convention

Treasurer's Report

Report of the Nominating Committee (first reading)

Report of the Resolutions Committee (first reading)

President's Address

Election of Nominating Committee

Election of Delegates to National Convention

Recess

12:00 Noon

Luncheon—"Doctor's Day"—Grand Ball Room

Program—"The Lamplighters"

2:00 P. M.

Second Business Session—Pine Room

Report of Roll Call Chairman

In Memoriam

Credits and Awards Report

Presentation of County Presidents and District Directors

3:00 P. M.

"What's your line?"—Discussion groups

7:30 P. M.

Annual Banquet, Ohio State Medical Association
—Grand Ball Room

THURSDAY, APRIL 12

8:30 A. M.

Registration—Assembly Foyer—Mezzanine

9:00 A. M.

Third Business Session—Ohio Room

Report of Roll Call Chairman

Report of Convention Chairman

(Continued on Page 302)



Edrisal* in Dysmenorrhea

“The most satisfactory antispasmodic for use in spastic dysmenorrhea is . . . Benzedrine* Sulfate”¹—one of Edrisal’s 3 ingredients. Edrisal’s other ingredients are aspirin and phenacetin.

‘Edrisal’ Analgesic—Antispasmodic—Antidepressant

Two tablets every 3 hours

Smith, Kline & French Laboratories, Philadelphia

Formula: Each ‘Edrisal’ tablet contains:

Benzedrine* Sulfate	2.5 mg.
(racemic amphetamine sulfate, S.K.F.)	
Aspirin	2.5 gr.
Phenacetin	2.5 gr.

1. Medical Gynecology, ed. 2, Philadelphia, 1950

*T.M. Reg. U.S. Pat. Off.

Report of Finance Committee
 Report of Resolutions Committee (second reading)
 Report of Nominating Committee (second reading)
 Election of Officers
 Installation of Officers and Address—Mrs. Mason G. Lawson, President, Woman's Auxiliary to the American Medical Association
 Inaugural address—Mrs. William H. Evans
 Presentation of Past-President's pin
 Presentation of Gavel and President's pin
 Adjournment

12:00 Noon

Cocktail Party—Guests of Cleveland Auxiliary—Pine Room

12:30 P. M.

Luncheon—Euclid Ball Room

1:30 P. M.

Style Show

2:30 P. M.

Post Convention Board Meeting

Mrs. William H. Evans presiding

Higher Rating for Physicians Announced by the Army

All Army physicians and dentists in the grade of first lieutenant who have at least one year of professional experience will be advanced to the temporary grade of captain within the next two months, Major General Silas B. Hays, the Army Surgeon General, announced.

The advancements, which affect an estimated 1,100 medical and 500 dental first lieutenants, are the result of a revised personnel policy which makes physicians and dentists eligible for the grade of captain after one year or more of professional experience.

The new policy will not impede the promotion of nonmedical officers, because the Department of Defense has authorized the advancements to be made outside of the Army's regular quota of captains.

Starting in April, young physicians and dentists entering the Army will receive initial grades of captain if they have a year or more of professional experience. Thus, with the exception of military interns—who serve as first lieutenants—the lowest grade in the Army Medical Corps will be that of captain.

The new policy recognizes that doctors must have at least nine years of training beyond the high school level in contrast to the four years of formal education beyond high school required of most other officers at the time they are initially commissioned.

Warnings on Encroachment of Socialism To Be Theme of AAPS Columbus Meeting

On Thursday and Friday, April 5 and 6, at the Deshler-Hilton Hotel in Columbus, the Association of American Physicians and Surgeons will present a panel of speakers "that the members of the medical profession can ill afford to miss," Dr. Charles W. Pavey, Columbus, president-elect of AAPS, announced.

In addition to the regular business sessions of the assembly and the House of Delegates, there will be a panel of speakers discussing "the various routes to Socialism upon which our country is now embarked." This panel discussion is a continuation of the same subject first used at the 1955 convention in Pittsburgh.

The subjects are:

"To Socialism (and Socialized Medicine) by Way of:

"Universal Military Conscription"—General Bonner Fellers, executive director of the organization "For America." (Thursday, 3:00 p. m.)

"Advanced Education"—Prof. E. Merrel Root, professor of English at Earlham College and author of the recent addition to the libertarian literature, *Collectivism on the Campus*. (Thursday, 3:45 p. m.)

"Compulsory Unionism"—Thurman Sensing, Nashville, Tenn., executive vice-president of the Southern States Industrial Council. (Friday, 10:00 a. m.)

"Federal Aid to Education," Frank Chodorov, member of the staff of the Foundation for Economic Education, former editor of *Freeman Magazine* and exponent of the libertarian philosophy. (Friday, 10:45 a. m.)

"Complacency of Physicians," Edward R. Annis, M. D., practicing surgeon in Miami, Fla. (Friday, 2:00 p. m.)

"Tax Exempt Foundations," The Honorable Carrol Reece, United States Representative from Tennessee. (Friday, 2:45 p. m.)

At the annual banquet on Friday evening, Dean Clarence A. Manion will "point the way out of this distressing situation." He is former dean of Notre Dame Law School and a leading exponent of the Bricker Amendment. He also conducts the Manion Forum of Public Opinion, which has been described as "one of the most powerful libertarian voices on the air waves."

All Ohio physicians, whether or not members of the AAPS, are urged to attend these sessions and bring their wives as guests, Dr. Pavey announced.

Medical Librarians To Meet

The Medical Library Association will hold its 55th annual meeting from June 18 to 22 at the Hotel Statler in Los Angeles, Calif. Details may be obtained from Mrs. Ella Crandall, Librarian, Los Angeles County General Hospital, 1200 No. State St., Los Angeles 33, Calif.

Hotel Reservation . . .



It's only another month until the 1956 ANNUAL MEETING of the OHIO STATE MEDICAL ASSOCIATION. Assure yourself and party excellent accommodations by filling out the coupon below NOW and mailing it to the hotel of your choice. The place is CLEVELAND; the dates, APRIL 10, 11 and 12.

NAME AND LOCATION	SINGLE	DOUBLE	DOUBLE TWIN BEDS
STATLER HOTEL, Euclid & E. 12th (Headquarters Hotel)	\$6.00-13.00	\$10.00-16.00	\$11.00-18.50
AUDITORIUM HOTEL, 1315 E. 6th St.	\$4.50- 8.00	\$ 7.50-10.00	\$10.00-12.00
CARTER HOTEL, Prospect & E. 9th St.	\$4.75- 8.00	\$ 7.25-11.00	\$ 8.50-12.50
CLEVELAND HOTEL, Public Square	\$6.00-10.00	\$ 8.50-10.00	\$12.00-17.00
HOLLENDEN HOTEL, 610 Superior Ave.	\$5.00- 9.00	\$ 8.00-12.50	\$ 9.00-16.00
MANGER HOTEL, 1802 E. 13th St.	\$5.50- 9.00	\$ 7.50- 9.00	\$10.00-14.00
OLMSTED HOTEL, Superior & E. 9th St.	\$4.25- 9.00	\$ 7.00-11.00	\$ 8.50-11.00

Persons who desire additional accommodations are advised to specify their needs to the hotel of choice.
(All Rates Subject to Change)

HOTEL RESERVATION BLANK
Mail the coupon to hotel selected

Manager Cleveland, Ohio
(Name of Hotel)

You are requested to reserve the following accommodations during the period of the Annual Meeting of the Ohio State Medical Association, April 10, 11, 12, 1956, or for such other period as may be indicated herein.

- ☐ Single Room with Bath
- ☐ Double Room with bath
- Price
- ☐ Twin Bed Room with Bath
- ☐ Suite

Arriving April.....at.....A. M.....P. M.

PLEASE VERIFY MY RESERVATION

Name.....
Address.....
.....

Notifiable Diseases . . .

New Official Form for Reporting Communicable Diseases Simplifies This Procedure; List of Diseases Reportable by Physician Is Given

THE OHIO Department of Health has introduced a new Confidential Case Report form, effective January 3, to be used for reporting of all communicable diseases, Dr. Ralph E. Dwork, director, announced. This one form replaces the former three separate and different report forms, one for reporting tuberculosis, another for venereal disease, and still another for other communicable diseases.

This new morbidity report form, (Form PHS 2430 9-55) was approved by the 36th Annual Conference of Local Health Commissioners, and is now being introduced in Ohio in order to improve the timeliness, completeness and quality of disease reporting, Dr. Dwork said. In addition it is anticipated that the use of the single form will result in less work for physicians, local health departments, hospitals and others responsible for making such reports.

AVAILABLE NOW

The new forms are available from local health departments.

It should be noted that the 1955 National Tuberculosis Association classification must be used in reporting "active status" in tuberculosis since the term "arrested" has been discontinued.

This new form was designed for nationwide use, therefore the last entry on the front of the form, "Report by number of cases only," is to be disregarded since this item does not apply in Ohio.

The use of franked envelopes for mailing morbidity report will remain the same.

Each case of notifiable disease is to be reported on an individual card.

This announcement from the Ohio Department of Health brings to attention the responsibility of physicians in this respect. The State Regulation states: "Every physician practicing in the

state of Ohio shall be primarily responsible for submitting the report of a case of notifiable disease, disability or infestation in any person attended by him." Reports of cases of inflammation of the eyes in the newborn and gonorrheal ophthalmia should be submitted within six hours. Other notifiable diseases are to be reported within 12 hours of the diagnosis of the condition. In lieu of written reports, attending physicians are authorized to report verbally to their local health commissioners.

Following is a list of notifiable diseases, including animal bites and infestations:

NOTIFIABLE DISEASES

Anthrax	Meningococcus meningitis (cerebro-spinal fever)
Brucellosis	Mumps
Chancroid	Paratyphoid fever
Chickenpox	Pertussis
Diarrhea, epidemic, of newborn	Plague (bubonic, pneumonia and septicemic)
Diphtheria	Polioomyelitis
Dysentery, amebic (ambiasis)	Psittacosis
Dysentery, bacillary (shigellosis)	Q Fever
Encephalitis (arthropod-borne)	Rabies
Encephalitis (other types)	Rheumatic fever
Food Poisonings:	Rocky Mountain spotted fever
1. botulism	Rubella (German measles)
2. staphylococcal	Salmonellosis
Gonococcal infections (specify type)	Scarlet fever
Granuloma inguinale	Smallpox (variola)
Hansen's disease (leprosy)	Syphilis
Hepatitis:	Tetanus
1. acute infectious	Trachoma
2. homologous serum	Trichinosis
Histoplasmosis	Tuberculosis:
Influenza	1. pulmonary
Impetigo (institutional)	2. non pulmonary
Leptospirosis	Tularemia
Lymphopathia venereum	Typhoid fever (including confirmed carriers)
Malaria	Typhus fever
Measles	Yellow fever
	Animal bites
	Infestations



MARY POGUE SCHOOL, Inc.

Complete facilities for training Retarded and Epileptic children educationally and socially. Pupils per teacher strictly limited. Excellent educational, physical and occupational therapy programs.

Recreational facilities include riding, group games, selected movies under competent supervision of skilled personnel.

Catalogue on Request

G. H. MARQUARDT, M. D.
Medical Director

BARCLAY J. MacGREGOR
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All four Pablum varieties are especially enriched with iron in its most assimilable form. And all are enriched with thiamine, riboflavin, calcium, phosphorus and copper.

To be sure infants *enjoy* Pablum Cereals, our scientists work tirelessly to make them wonderfully smooth in texture, delightfully delicate in flavor. For your young patients, suggest:

Pablum Mixed Cereal

Pablum Barley Cereal

Pablum Rice Cereal

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DIVISION OF MEAD JOHNSON & CO., EVANSVILLE, INDIANA

MANUFACTURERS OF NUTRITIONAL AND PHARMACEUTICAL PRODUCTS.



Do You Know? . . .

In September 86 approved Blue Cross Plans, located in the United States, Canada and Puerto Rico passed the 50 million membership mark. Nearly one out of every three persons in the United States now is a Blue Cross member.

* * *

On January 1 of this year Dr. Walter S. Unger, of Melbern, delivered his great grandson in the Cameron Hospital of Bryan. Fifty-seven years ago next April he delivered the baby's grandfather who is his own eldest son. About midway between those two events Dr. Unger delivered the New Year's baby's father and mother. In another family also Dr. Unger delivered three generations.

* * *

The Zanesville Business and Professional Woman's Club named Dr. Beatrice Hagen to receive the Woman of the Month Award. Wearer of the State Association 50-Year Pin, she served 22 years as Zanesville and Muskingum County health commissioner.

* * *

Dr. Clarence A. Mills, Cincinnati, discussed "Sickness and Death Threshold in Los Angeles Smogs," in Los Angeles at the invitation of the medical and pollution control authorities of that city. Dr. Mills is director of the University of Cincinnati College of Medicine laboratory for experimental medicine.

* * *

Infant mortality continued to improve in 1955 and the rate will be about 26 per 1,000 live births, a new low for the United States.

* * *

Dr. Leon Schiff, professor of clinical medicine, University of Cincinnati College of Medicine, took part in the fifth Pan-American conference on gastroenterology held in Havana, Cuba, late in January. He was one of a committee of six named to standardize the nomenclature of chronic liver diseases.

* * *

Consolidation of the health boards of Crawford, Wyandot and Marion Counties has been announced. Dr. T. R. Laughbaum, of Bucyrus, who has been serving as health commissioner of Wyandot and Crawford Counties for several years, will serve for the time being as commissioner for the combined district. Dr. Laughbaum has announced his wish to retire as soon as a successor is found.

* * *

Dr. Herman J. Bearzy, chief of physical medicine and rehabilitation at Miami Valley Hospital, Dayton, was elected to the Board of Directors of the National Foundation for Muscular Dystrophy, Inc., at the annual board meeting in New York recently.

New Chief of Ohio Hospital Facilities Office Named

Dr. Margaret DuBois, chief of the Connecticut State Health Department's Division of Hospital Facilities for the past five years, was named to a similar post in the Ohio Department of Health in January. Dr. DuBois will be in charge of Ohio's programs of hospital facilities and civil defense. She will be concerned with administering Hill-Burton funds, hospital licensing, certificates of hospital compliance with minimum standards, and developing and co-ordinating civil defense programs in hospitals.

Dr. DuBois is a graduate of the Medical School, University of Toronto, and did postgraduate work in hospital administration at the University of Chicago. Earlier, she had been associated with University Hospitals, Cleveland. She is a former field representative with the American College of Surgeons and associate professor of hospital administration and assistant hospital director at the Medical College of Virginia, Richmond.

Ohio Is Well Represented at First Medical Executives' Institute

The First Institute of the Medical Society Executives Conference was held in Chicago, February 6-8.

Charles S. Nelson, Executive Secretary of the Ohio State Medical Association, spoke to the group on the subject, "The Purview of the Medical Association Executive." Other members of the Columbus Headquarters office staff who attended were George H. Saville, Hart Page and Gordon Moore.

Executive Secretaries of Ohio County Medical Societies who attended were Edward F. Wilkenborg, Academy of Medicine of Cincinnati; Robert F. Freeman, Montgomery County Medical Society; Robert W. Elwell, Academy of Medicine of Toledo; M. John Hanni, Academy of Medicine of Cleveland; Stanley R. Mauck, Columbus Academy of Medicine, and William Webb, new assistant executive secretary of the Columbus Academy; and Mrs. Mary B. Herald, Mahoning County Medical Society.

Approximately 240 persons attended the conference.

Cincinnati Area General Physicians

The Southwestern Ohio Society of General Physicians in collaboration with the College of Medicine of the University of Cincinnati presented a postgraduate course January 22 on the subject, "Neuropsychiatry in General Practice."

We Apologize

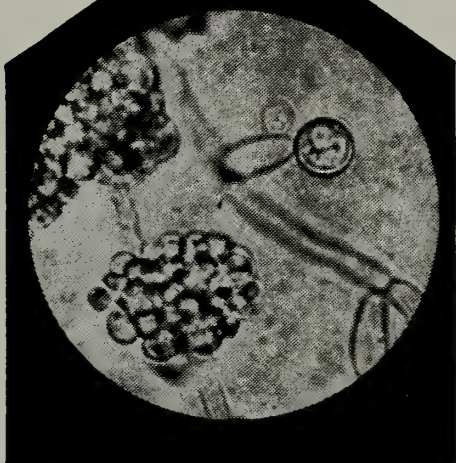
In a news article in the February issue, *The Journal* stated that Wilson L. Benfer is superintendent of the Toledo State Hospital. This was an error. Mr. Benfer is superintendent of The Toledo Hospital.

*the only broad spectrum
antibiotic preparation that...*



**1 provides the antimicrobial
activity of tetracycline**

Because it contains Steclin (Squibb Tetracycline), the well tolerated broad spectrum antibiotic, MYSTECLIN is an effective therapeutic agent for many common infections. Most pathogenic bacteria, as well as certain large viruses, certain Rickettsiae, and certain protozoans, are susceptible to Mysteclin.



**2 protects the patient against
monilial superinfection**

Because it contains Mycostatin (Squibb Nystatin), the first safe antifungal antibiotic, MYSTECLIN acts to prevent monilial overgrowth frequently observed during broad spectrum antibiotic therapy. Manifestations of this overgrowth may include some of the diarrhea and anal pruritus associated with antibiotic therapy, as well as vaginal moniliasis and thrush. On occasion, serious and even fatal infections caused by monilia may occur.

Mysteclin

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Minimum adult dose: 1 capsule q.i.d.

Supply: Bottles of 12 and 100.

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Are You Eligible To Vote? . . .

March 28 Is an Important Date—the Last Day for Registration for Those Who Wish To Exercise Their Franchise in the May 8 Primaries

ANOTHER important election date is coming up—May 8. This is the date of the Party Primary Elections, at which the scene will be set for the November 6 General Election.

For some physicians in Ohio, and perhaps for many members of their families and friends, March 28 is an equally important date. This is the last day for registration for those who must register before they are eligible to vote.

Registration is a simple matter. Here are the points to be remembered, presented in question and answer form from information furnished *The Journal* by Secretary of State Ted W. Brown:

What is the registration deadline?

Forty days before the Primary Election, or March 28.

Who must register?

Every citizen who resides in a "registration district" must be registered with his county Board of Elections before he is eligible to vote.

What is a registration district?

The county Board of Elections must maintain a registration of eligible voters in every city of 16,000 population or over. Municipalities of less than 16,000 population may elect to maintain registration. The Board of Elections of a county may require registration in the entire county or in certain precincts. A registration district, therefore, may be a county, a municipality, a group of precincts or a single precinct.

How does a person know whether he is in a registration district or in a non-registration area?

If he resides in a municipality of 16,000 population or over, he must be registered. If he resides in a suburban community, a small municipality or a rural area, and is in doubt, he should phone the county Board of Elections and ask.

Under what conditions must a person re-register?

Registration is permanent, subject to the following exceptions:

a. If the citizen has not voted in a general, primary or special election since January 1, 1954, he must register again.

b. If the citizen has changed name—e. g., if a woman has married—she must re-register. If a woman marries between March 28 and May 8, she may vote on May 8 under her former name.

c. A veteran of the armed services must register after he is discharged.

d. A voter who changes his place of residence from one county to another, must register with the Board in the county to which he moves if his new residence is in a registration precinct. A voter who changes his residence to a new address within a registration district must notify his Board of Elections of such change. Some boards require the voter to present himself in person; others accept written notice.

What is the procedure for voters in non-registration areas?

In precincts not in registration districts, citizens are automatically eligible to vote. A voter may be required at the polling booth to produce evidence to the satisfaction of the election judge, or under oath, that he is qualified to vote.

What is the residence requirement for registration?

A person who will have met the residence requirement for voting by May 8—that is, will have lived in the State one year, in the county and precinct 40 days, and is otherwise qualified to vote—may register on or before March 28.

If he has moved his residence between March 28 and Election Day, what can he do?

Vote at the precinct from which he moved.

If a citizen has moved or is planning to move prior to March 28, may he vote at the precinct in which he formerly resided?

No. If he does not qualify himself to vote in the new precinct by notifying the Board of change of address, he will have lost his privilege of voting on May 8.

Suppose he moves his residence on March 27?

He will have been in the new precinct for 40 days by Election Day and, therefore, may register immediately.

If a citizen in a registration district will reach his 21st birthday between March 28 and May 8, may he register?

Yes. He may register on or before March 28.

If a person who resides in a non-registration area will be 21 years old on or before May 8, what is the procedure?

If he meets other requirements of a voter, he will automatically become eligible to vote.

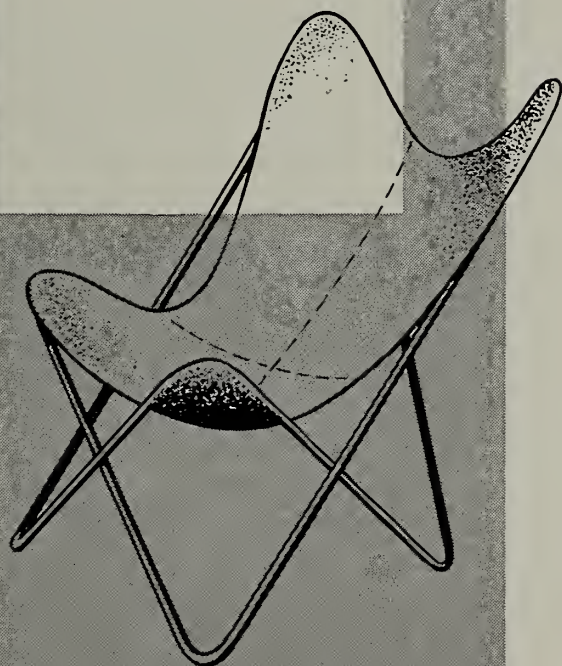
Where does one register?

At the headquarters of the Board of Elections

FOR HYPERTENSION



"AN ALLIANCE
OF THE CLASSIC
AND CONTEMPORARY"



Synergistic Therapy with New **THEOMINAL[®] R.S.**

Now you can give your hypertension patients the compound therapeutic advantages of two successful hypotensive agents: Theominal (theobromine with Luminal[®]) and purified Rauwolfia serpentina alkaloids.

THEOMINAL R. S. gives
*Better Control of Cardiovascular
and Subjective Symptoms*

Theominal R. S. offers both the vasodilator and myocardial stimulant actions of theobromine with Luminal and the moderate central hypotensive effect of Rauwolfia serpentina. Gentle sedation calms the patient and a feeling of "relaxed well-being" is established. With Theominal R. S. the therapeutic potency of each of the components is enhanced and the chance of a patient's sensitivity to any one drug is lessened.

Each Theominal R. S. tablet contains:

Theobromine	0.32 Gm. (5 grains)
Luminal	10 mg. (1/8 grain)
Purified extract of Rauwolfia serpentina alkaloids	1.5 mg.

DOSE: 1 tablet two or three times daily.

SUPPLIED: bottles of 100 and 500 tablets.

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LABORATORIES

NEW YORK 18, N. Y. WINDSOR, ONT.

THEOMINAL AND LUMINAL (BRAND OF PHENOBARBITAL), TRADEMARKS REG. U. S. PAT. OFF.

of county of residence or at polling places indicated by the Board.

Where does a student register?

In the county in which he maintained residence just prior to entering the institution of learning.

How does a disabled person register?

A voter who is prevented by sickness or physical disability from registering in person may apply to his county Board of Elections by mail or phone for registration forms. The application must state the facts as to the voter's disability. Both the registration forms and a declaration of the facts as to disability must be notarized, and both must be delivered to the Board of Elections by a reliable and responsible person. Some boards require this person to be a notary public.

What about persons in the armed forces?

Persons who are residents of a registration district and who are in active service in the armed forces, and are otherwise qualified to vote, may cast absentee ballots without previous registration.

Does this privilege extend to civilians who will be away from home on May 8?

No. Students and other persons who must be registered in order to vote and who plan to be away on May 8, should register now so that they will be eligible to cast absentee ballots.

ABSENTEE VOTING

Persons who will be away from home on May 8 should plan to cast absentee votes. Here are some dates to remember and other data on absentee voting:

Civilians who wish to cast absentee ballots must be qualified to vote the same as though they were voting at home; e.g., they must be registered if they live within a registration area.

Civilians must apply for ballots on forms furnished by election boards. Upon receipt of filled out applications, boards will mail ballots which are to be properly filled out and returned in accompanying "identification" envelopes.

Ohioans who will be more than 10 miles from their polling places and outside their home counties on election day are eligible for absentee voter ballots.

Applicants for primary ballots must designate their party affiliation. Otherwise, there is no way to tell whether they should receive ballots listing Democratic or Republican candidates.

March 9—First day for civilians outside the continental limits of the United States, such as wives of military men, to apply for absent voter ballots.

March 28—Last day for persons who must register in order to qualify for voting, to register with their local Board of Elections.

April 8—First day for absent and disabled

voters within the United States to apply for ballots.

May 3—Last day for "absent or disabled" civilians to apply. The deadline is 4 p.m.

May 4—Last day for civilians to return voted ballots to election boards to have them count. The deadline is noon of that day. Military personnel have until noon of election day, May 8.

May 5—Last day for members of the armed services to apply for ballots. Their deadline is 12 noon. Military service personnel have been eligible to apply for ballots since January 1.

All Aboard For AMA's Chicago Meeting

Plans are rapidly taking shape for the AMA's 105th Meeting June 11-15 in Chicago. AMA has lined up nearly five full days of lectures, scientific and technical exhibits, color television and motion picture presentations to give physicians a good "short course" in postgraduate medical education.

The convention will center its activities at Navy Pier, Northwestern University, and near north side hotels. Headquarters for the House of Delegates will be at the Palmer House.

Some 350 Technical Exhibits and more than 300 Scientific Exhibits will be on display all week. The exhibit hall will be open "for doctors only" probably on Wednesday and Thursday mornings.

A few outstanding scientific features already scheduled include: fracture and fresh pathology exhibits; physical examinations for physicians; exhibit-symposiums on traffic accidents and arthritis and rheumatism; special exhibits on cardiovascular diseases and pulmonary function tests.

Physicians should begin now to make plans to attend this worthwhile medical meeting.

M & R Laboratories Changes Name To Ross Laboratories

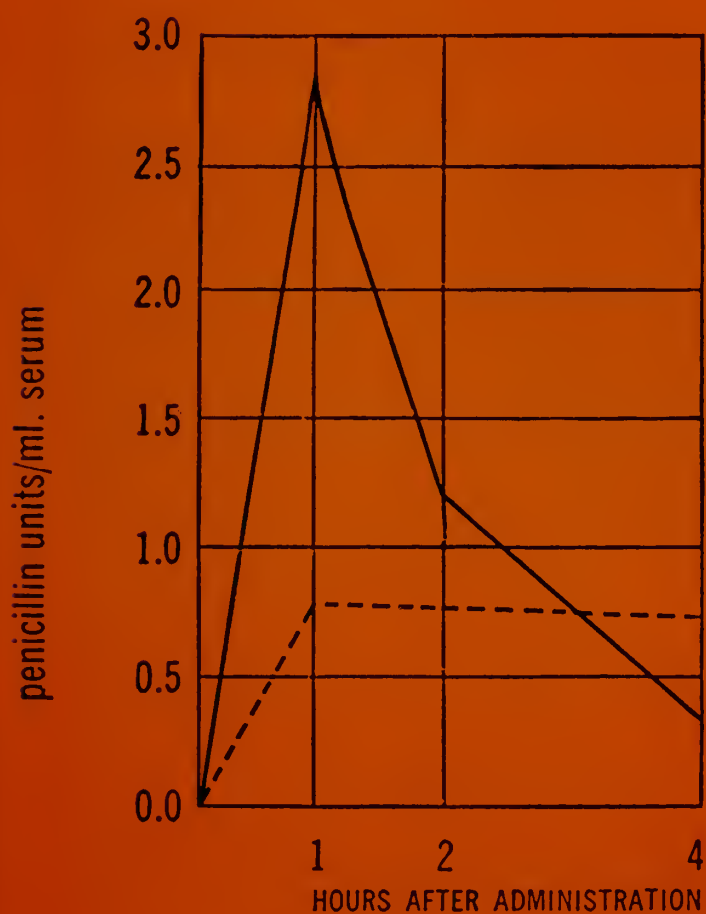
M & R Laboratories of Columbus, pioneers in the field of infant nutrition, will be known as Ross Laboratories as of March 1, it was announced by Harry C. Moores, chairman of the board. The change commemorates the name of Stanley Ross, one of the founders of the company 53 years ago.

Mr. Moores said the name change will not affect the policy, personnel or the organization of the company, whose leading product is Similac. The laboratories will continue to promote its products only to the medical profession, and will stress the need for basic research by continuing to sponsor the pediatric research conference program instituted by M & R, he stated.

ORAL PENICILLIN WITH *INJECTION* PERFORMANCE



Now! A 500,000-unit tablet for higher, faster blood levels than from injected procaine penicillin



— PEN·VEE·Oral, 500,000 units,
one tablet, 19 subjects¹
- - - Procaine Penicillin G, 600,000 units,
one injection, 10 subjects²

Supplied: PEN·VEE·Oral Tablets, 500,000 units, scored, bottles of 12; 200,000 units, scored, bottles of 36. Also available: BICILLIN®·VEE Tablets, 100,000 units of benzathine penicillin G and 100,000 units of penicillin V, bottles of 36.

1. Wright, W.W.: Personal communication.
2. Price, A.H.: Personal communication.

PEN·VEE·Oral*

Penicillin V, Crystalline (Phenoxymethyl Penicillin)



®
Philadelphia 1, Pa.

Trademark

Facts and Policies About Annual Dues...

Amount of Dues; Date Due; Payable to Whom?; Those Exempt From Payment; Data on AMA Dues and Exemptions; Getting Journals

HERE are some important facts and reminders regarding 1956 membership dues. It is vital for each physician to keep his membership in the State Association, his County Medical Society, and the AMA up to date. Those who have not paid 1956 dues should get in touch with their County Society secretary-treasurer immediately.

Amount of Dues: State Association, \$20.00 or \$7.50 in the case of interns and residents; AMA, \$25.00; County Society, amount varies from county to county—See your local secretary-treasurer.

Membership and Dues for Residents and Interns: A physician serving a hospital internship or residency within a period of five years following graduation from medical school (excluding time in military service), who becomes a member of a county medical society and meets the membership eligibility requirements of the OSMA By-Laws, does not have to pay full state dues for 1956. By official action of The Council on December 10, 1955, state dues for such members were set for 1956 at \$7.50. Such members will not receive *The Journal* automatically but may subscribe to *The Journal* at one-half the regular rate—namely for \$2.50.

So far as AMA membership is concerned, the AMA By-Laws provide that it may excuse from the payment of AMA dues, interns and residents during the first five years following graduation from medical school (excepting military service) provided their local and state dues are fully or partially waived. Therefore, intern and resident members in Ohio who are assessed the partial dues (\$7.50) will be entitled to AMA membership without payment of AMA dues. However, in order to receive the *AMA Journal* or some other AMA publication, they will have to purchase a regular subscription from the AMA.

Date Dues are Due: On or before January 1, 1956. Membership is on a calendar year basis.

Dues Payable to Whom?: Secretary-treasurer of County Medical Society. When paying dues to him, send check for total amount of local, State and AMA dues. Maintaining membership in the AMA is optional, but the large majority of Ohio physicians belong to the AMA. Don't send dues direct to Columbus Office—pay them to local secretary-treasurer.

Who is Exempt From State Dues? There are only two classes of members of the OSMA who are exempt from the payment of state dues, namely:

(a) **Military Members:** Members of the OSMA

on extended active duty in the military service or U.S. Public Health Service but who are not making military medicine or public health work a career, are entitled to exemption from OSMA membership dues while they are in the service. Dues paid by a member before entering the service will not be refunded, but dues will be waived if he enters the service prior to paying dues. Certification from local secretaries will be necessary in all such cases.

(b) **Aged or Disabled Members:** A member who retires, or has been retired, from active practice because of age or disability and who was in good standing at the time of retirement is exempt from the payment of State dues, providing he requests such exemption and such request is approved in writing by the secretary-treasurer of his county medical society.

Remember: The determining factor is not how old the physician is but whether he has retired from active practice.

Who Is Exempt From AMA Dues?: The following physicians, who are members of the OSMA either through payment of OSMA dues or by exemption of OSMA dues, can carry membership in the AMA without paying AMA dues:

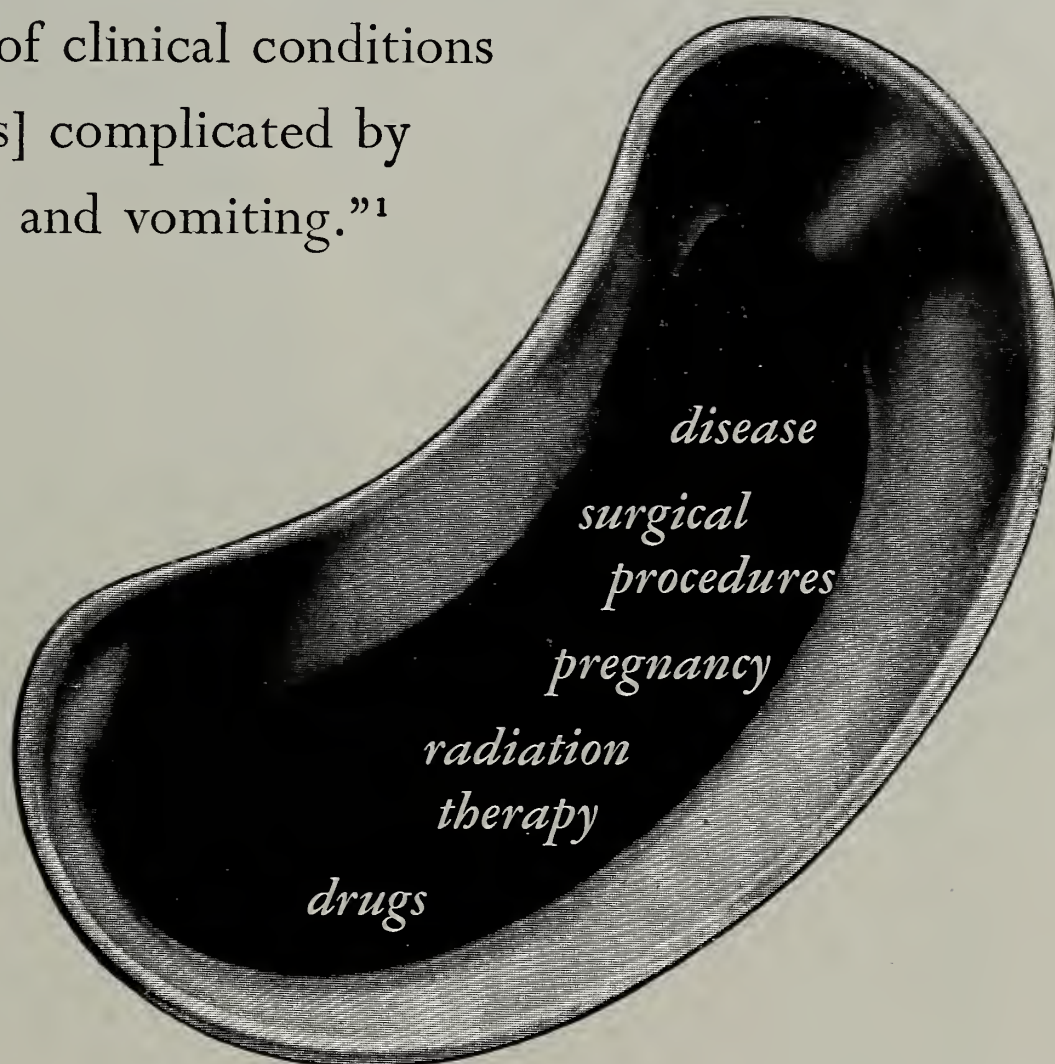
(a) **Military Members:** OSMA members in temporary military service prior to January 1, 1956, are entitled to AMA membership without payment of dues. Members entering military service prior to July 1, 1956, will owe AMA membership dues of \$12.50—one-half year; those entering military service after July 1, 1956, will owe dues for the entire year—\$25.00. Military members for whom AMA dues are waived and who desire to receive *The AMA Journal* while in the service may do so by buying, directly from the AMA, an annual subscription in the amount of \$15.00. The *OSMA Journal* is sent to such members without charge.

(b) **Aged and Disabled Members:** OSMA members who are exempt from payment of OSMA dues because of retirement from active practice due to age or disability are entitled to AMA membership without payment of AMA dues. The names of such members will be certified automatically to the AMA annually by the Columbus Office after their names are entered on the OSMA roster as dues-exempt members for the current year.

(c) **Members 70 years of age:** Members of the OSMA, after attaining the age of 70 years, will be eligible for membership in the AMA without paying AMA dues, starting on January 1 following such member's 70th birthday, providing

THORAZINE*

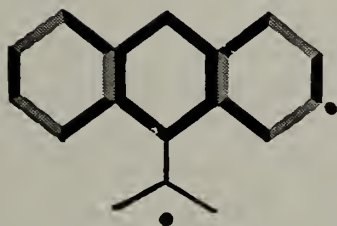
"An effective antiemetic agent for a wide range of clinical conditions [and situations] complicated by nausea and vomiting."¹



1. Moyer, J.H., et al.: Arch. Int. Med. 95:202 (Feb.) 1955.

'Thorazine' is available in ampuls, tablets and syrup (as the hydrochloride), and in suppositories (as the base).

'Thorazine' should be administered discriminately and, before prescribing, the physician should be fully conversant with the available literature.



Smith, Kline & French Laboratories, Philadelphia

*T.M. Reg. U.S. Pat. Off. for chlorpromazine, S.K.F.

such member requests such exemption. Such members should file their request for AMA exemption with the Columbus Office after they have received their OSMA membership card for 1956, or any subsequent current year. The Columbus Office will certify their names to the AMA. This AMA exemption will be automatic year by year, providing the physician's name is carried on the membership roster of the OSMA, either as a dues-paying member or as a retired member. To get the *AMA Journal* these 70-year-old members must purchase a subscription.

(d) Members of the OSMA who are serving an internship or residency during the first five years following graduation from medical school (excluding time in military service). This is because their dues are partially waived by the OSMA (they pay only \$7.50 to OSMA). Those in postgraduate training after the five-year period are not excluded from paying AMA dues.

Those not exempt from OSMA dues: The following are not exempt from the payment of OSMA dues, either \$20.00 or \$7.50:

(a) **Members in practice or in internship or residency training.** As mentioned previously, those in internship or residency during the first five years following graduation from medical school (excluding time in military service) are assessed dues of \$7.50—not \$20.00 the dues of other classes of paying members.

(b) **Regular commissioned medical officers of the Army, Navy, Air Force, or U. S. Public Health Service, and permanent medical officers of the Veterans Service and the Indian Service are NOT exempt from OSMA dues.** If they desire to be members of the OSMA, they must qualify the same as civilian physicians and pay current dues. However, physicians of these classes are eligible to apply for **Service Membership in the AMA**, and if accepted into Service Membership, will not be required to pay AMA dues.

Send Change of Address Promptly: Occasionally a new member wonders why he does not receive the OSMA and AMA journals at once. The answer is simple. It takes the OSMA Columbus Office about four weeks to get a new stencil made and the mailing list adjusted to take care of mailings to new members. It takes the AMA longer because of its very large mailing list. Also, some months extra copies of the journals are quickly exhausted. Moreover, the Post Office Department frequently causes the delay in delivery. The Columbus Office makes a real effort to send out OSMA journals to new members by special handling but that can't always be expedited. If a new member fails to get the magazine on two consecutive months, something is wrong and he should notify the Columbus Office. All members can help the Columbus Office in keeping the mailing list up to date by sending in changes of address promptly.

Journals: State Association members, who pay

full dues or are exempt from payment of any dues, receive *The Ohio State Medical Journal* as a part of their membership privileges—no extra charge for *OSMA Journal*. Those who pay dues to AMA receive the *Journal of the AMA* as a part of their membership privileges—no extra charge for *AMA Journal*.

A dues-paying AMA member may secure in lieu of the *AMA Journal*, any other official publication of the AMA on special request by him direct to the AMA at 535 N. Dearborn Street, Chicago. These publications are: *Archives of Internal Medicine*, *American Journal of Diseases of Children*, *Archives of Dermatology and Syphilology*, *Archives of Neurology and Psychiatry*, *Archives of Pathology*, *Archives of Surgery*, *Archives of Otolaryngology*, *Archives of Ophthalmology*, and *Archives of Industrial Hygiene and Occupational Medicine*.

Those exempted from payment of AMA dues must place a special subscription for the *AMA Journal* direct to the AMA or any one of the other publications if they desire to receive such publication.

VA Sponsors Clinical Conference Series in Cleveland

The Cleveland Regional Office of the Veterans Administration is sponsoring a series of weekly clinical conferences to run during March, April and May, Dr. Charles Berns, chairman, announced. All interested physicians are invited to attend. The conferences are held on Wednesday mornings from 8:00 to 9:00 o'clock in the Conference room, seventh floor, Cuyahoga Building, Cleveland.

Following are the dates, topics to be discussed and speakers:

March 7—"Hereditary Diseases of the Nervous System"—Dr. H. N. Roback.

March 14—"Vertigo, Tinnitus, and Deafness"—Dr. I. I. Cramer.

March 21—"Dissecting Aneurysm of the Aorta"—Dr. Francis Bayless.

March 28—"Comparison of The Various Opaque Media Used in Urography"—Dr. H. R. Trattner.

April 4—"Fact and Fad"—Phyllis A. Folda, nutritionist.

April 11—"Recent Developments in Treatment of Pulmonary Diseases"—Dr. D. N. Minnis.

April 18—"Presentation of Interesting Cases by the Department of Physical Medicine and Rehabilitation"—Dr. R. Lowry.

April 25—"Retrolental Fibroplasia"—Dr. J. J. Berry.

May 2—"Atherosclerosis"—Dr. L. J. Marcus.

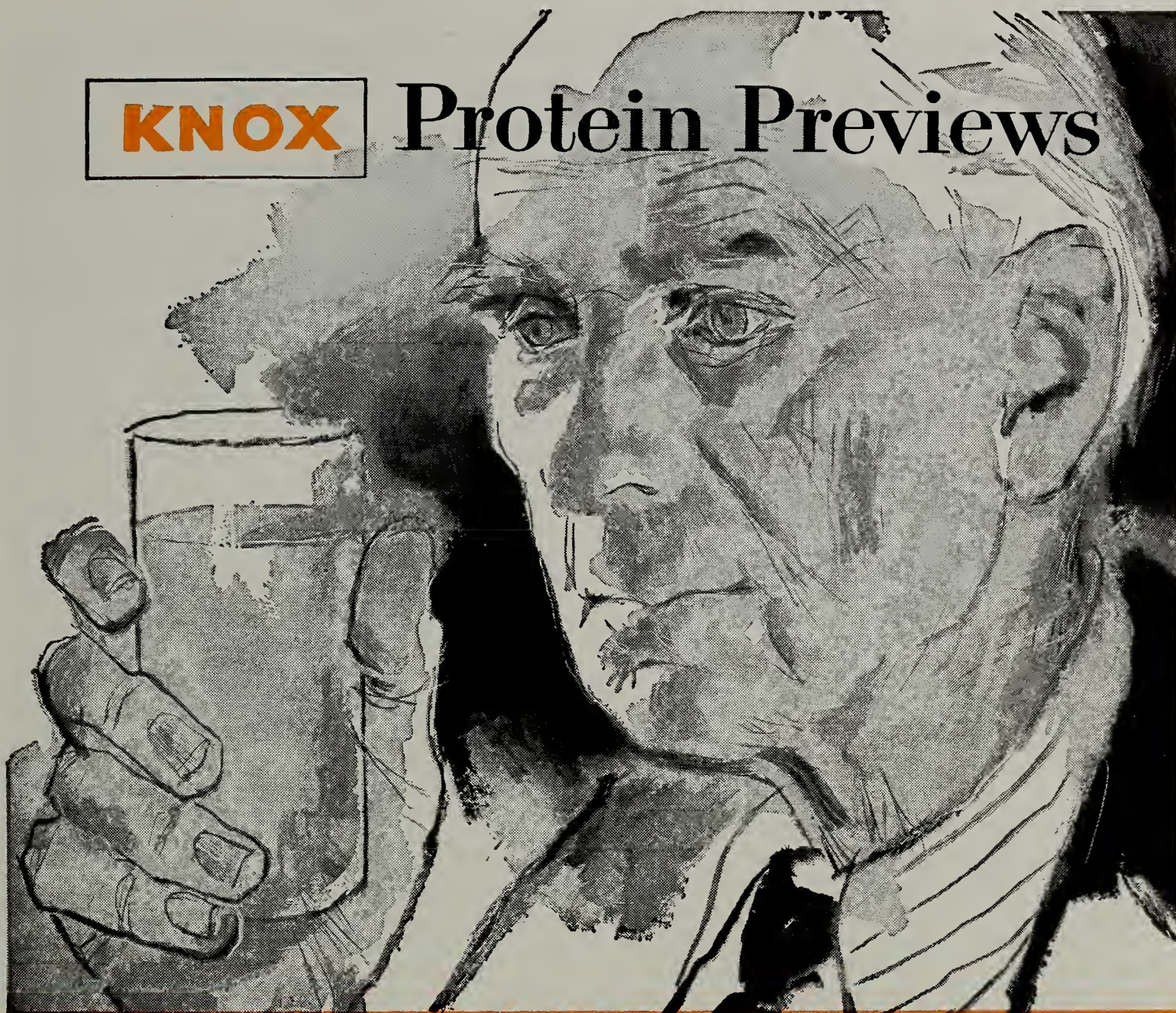
May 9—"Right Middle Lobe Syndrome"—Dr. J. S. Frankel.

May 16—"Interesting X-Ray Cases"—Dr. R. M. Iseman.

May 23—"Treatment of Malignancies with Nitrogen Mustard and Steroids"—Dr. S. W. Kessler.

KNOX

Protein Previews



Maintaining Lean Body Mass in the Edentulous Geriatric Patient



Extensive loss of body protein can occur in either the spare or obese geriatric patient. But whatever the patient's somatotype, a decrease in lean body mass is usually the result of inadequate protein intake due to poor dentition, slowed-down digestion and quite frequently, unappetizing main dishes.

Knox Gelatine is an excellent non-residue protein which is easy to chew and readily digested and assimilated. As a vehicle for many foods, Knox Gelatine brightens bland diets, giving a new interest to jaded appetites. As a concentrated protein drink, Knox Gelatine supplies seven out of eight essential amino acids and a majority of the other amino acids composing protein.

Specific suggestions on how to use Knox Gelatine in different types of geriatric diets are described in the booklets listed in the coupon below.

Chas. B. Knox Gelatine Company, Inc. SJ-15
Professional Service Department
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Indicate number of special diet booklets desired
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GERIATRIC _____ REDUCING _____
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YOUR NAME AND ADDRESS

In Our Opinion:

Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

BETTER GET BUSY NOW ON YOUR LOCAL EXHIBITS

Now is the time for County Medical Societies to make plans for exhibiting at the county fair or similar public gatherings. By contacting those in charge of exhibit space at this time, choice space can be secured.

Also, those in charge of the exhibits should get in touch with the Columbus Office soon if they want it to assist them. If plans call for use of AMA exhibits, it is important that contacts be made at once with the AMA Bureau of Exhibits. Reservations from all over the country are filled by the bureau as requests are received.

In other words: The early birds will get the best space and the best exhibits.

PLAN TO ATTEND CONFAB ON MEDICAL WRITING

One of the innovations of the 1956 Annual Meeting, Cleveland, will be a "workshop" on medical writing. It will be on Wednesday morning, April 11, with the editor of *The Ohio State Medical Journal*, Jonathan Forman, M.D., in charge.

We hope that a considerable number of physicians will make it a point to attend this conference, which will be down to earth and practical. Almost any physician at some time or another has to prepare an article—either for the printed page or for oral presentation. There are right and wrong ways of doing it.

The seminar on April 11 undoubtedly will bring out some good suggestions and ideas. Better plan to attend.

PHYSICIAN, PATIENT AND MALPRACTICE

Referring to the big increase in the incidence of malpractice claims against physicians, the late Dr. Louis J. Regan, Los Angeles, one of the country's leading authorities on medical-legal questions, in a recent talk emphasized that it becomes absolutely necessary that the physician learn what he may do to safeguard himself and how to put himself in the best possible position for efficient defense against the seemingly inevitable suit. Dr. Regan then proceeded to offer the following advice and suggestions which are so important to every reader of *The Journal* that we hope each will clip out this reference and read it again and again:

He must care for every patient with meticulous attention to the requirements of good practice.

He must carefully see to it that there is sufficiency of observation, investigation, and treatment, including the utilization of every indicated laboratory aid.

He must exercise care in selecting and in delegating duties to his assistants.

He must maintain a safe environment in which to work, causing instruments to be checked and apparatus to be calibrated as required in the exercise of ordinary care.

His obligation comprehends instructing those caring for the patient, so that all things needed may be carried out during his absence, and providing for the protection of those coming in contact with the patient.

He must recognize the importance of psychological factors and constructively influence the nervous, mental, and emotional balance of his patient by tactful and intelligent handling, instituting such psychotherapeutic measures as may be indicated.

His personal relation with his patient is of extreme importance, for a friendly patient, one who feels that everything possible is being done for him, is not likely to sue his physician even when the end-result is less than perfect.

From a medicolegal point of view the importance of good medical records cannot be over-emphasized.

Consultation should be secured when (1) the patient is not doing well; (2) there is any unexpected reaction, untoward occurrence, or a complication or sequela develops; and (3) whenever the patient or his family is unduly complaining or expressing dissatisfaction.

All findings, recommendations, etc., should be reduced to writing and be made a part of the case record.

Both medical ethics and the physician's recognition and acceptance of his obligation prevent him from destructively criticizing the treatment rendered or the result obtained by a fellow practitioner. On the other hand, the physician will accept the opportunity to reassure and inform any patient who may be wrongfully condemning another doctor in respect to the latter's medical care.

OLDER CITIZENS AND THE MEDICAL PROFESSION

At a meeting of the recently created AMA Committee on Geriatrics, Dr. H. B. Mulholland, chairman of the committee, made the pertinent observation that medicine has been responsible in large part for the increase in the life span of the American people and now "must accept its

CLINICAL REVIEWS

MAYO CLINIC AND MAYO FOUNDATION

April 9, 10 and 11, 1956

ROCHESTER, MINNESOTA

This 3-day program will be devoted to lectures and discussions on problems of current interest in general medicine and surgery. The presentations will be made by staff members of the Mayo Clinic and the Mayo Foundation for Medical Education and Research.

The number of physicians who can be accommodated is necessarily limited. Those wishing to attend should communicate with Mr. R. C. Roesler, Mayo Clinic, Rochester, Minnesota.

There are no fees of any kind.

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THERAPY
in ALL AGE
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**...SAFE—PLEASANT TO TAKE
...ACCURATE DOSAGE
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...WILL NOT SEPARATE**

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TASTY, CHERRY FLAVOR and COLOR—ECONOMICAL!

There is no safer or more effective sulfonamide available! Extensive clinical trials show that triple sulfas (BUFFONAMIDE) have outstanding therapeutic efficiency among sulfa drugs.

Each Teaspoonful (5 cc.) Provides:

Sulfadiazine	0.166 gm.
Sulfamerazine	0.166 gm.
Sulfacetamide	0.166 gm.
BUFFERED with Sodium Citrate	0.5 gm.

At Pharmacies Everywhere!

Handy 2 oz. Dispenser Pints or Gallons

BUFFONAMIDE ASSURES:

- Widest possible antibacterial spectrum
- Highest blood level... Safely and quickly
- Maximum potency in smallest dose
- Minimal side effects



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share of the responsibility for assisting these older persons to live pleasant and useful lives."

These same sentiments were expressed by Dr. Edward L. Bortz, a member of the committee. He pointed out that the committee will study the development and maintenance of the older citizen as a useful and worthwhile member of society, adding that "this may require an entirely new concept of medical practice and a change in attitude, both professional and public, regarding older people and the aging processes."

This subject offers a real challenge to each medical society. It must be prepared to cooperate with the public in coping with this problem.

CONTRACTS MUST TAKE PUBLIC INTO ACCOUNT

A Common Pleas Judge in a Northeastern Ohio county has ruled that a partnership contract between two physicians prohibiting either from practicing within 30 miles of their joint location after the partnership is dissolved is "unreasonable and void."

The court pointed out that the agreement would have barred one of the physicians from practicing in an area in which physicians are badly needed.

The opinion follows the theory that the interest of the public must be considered in the making of contracts. Physicians entering into agreements of this kind or similar in character should keep that in mind.

CONTINGENT FEE ARRANGEMENT UNETHICAL

Here's a question which was dropped into the lap of the Judicial Council of the AMA not long ago:

"May I ethically obligate myself to render professional medical service for a fee that will be contingent upon the success or failure of litigation in which my professional services will play a part?"

Obviously, the physician asking the question should have known that such an act is unethical and unprofessional. This is what the Judicial Council had to say:

"Chapter I, section 6 of the Principles of Medical Ethics provides that remuneration received for professional services rendered the patient should be in the form and amount specifically announced to the patient at the time the service is rendered, or in the form of a subsequent statement. It is the opinion of the Judicial Council that the contracting for, or acceptance of, a contingent fee by a doctor, which is based on the outcome of litigation, whether settled or adjudicated, is unethical.

"The Judicial Council would point out that the laborer is worthy of his hire and that the physician, having only his services to sell, has an obligation to place a fair value on those services. Ethically this value should be based upon the

value of the service rendered by the physician to the patient and not upon the uncertain outcome of a contingency that does not in any way relate to the value of the service.

"Furthermore, the Council is of the opinion that the physician's obligation to uphold the dignity and honor of his profession precludes him from entering into an arrangement of this nature because, if a fee is contingent upon the successful outcome of a claim, there is the ever-present danger that the physician may become less of a healer and more of an advocate—a situation that does not uphold the dignity of the profession of medicine."

NO FUSS, NO MUSS, NO WORRY—NO PATIENTS

Reports the Washington Office of the AMA in a recent news letter:

"Paul H. Mallory and his Mallory Medical Factor System, designed to take all the book-keeping out of medical practice, staged a two-day public demonstration in Washington. The heart of the system is a univac or mechanical brain, described by Mr. Mallory as the 'factor.' It includes electronic accounting and recording machines. As Mr. Mallory visualizes the operation, physicians would set up and operate medical centers. From them would come daily reports giving the patient's name and the amount of the charge. These would be electronically noted under each patient's number. That would take care of the billing phase. For payments, each patient would come to an agreement with the operators of the univac as to how to pay his medical bill, and when. These payments would be automatically credited to the patient's univac number. Mr. Mallory points out that there would be no embarrassment anywhere if doctors would adopt his system; there would be no financial dealings between the patient and the doctor—univac would take care of that. If the patient had accounts with several doctors, any lump sum payment to the univac would be divided equally among them. Mr. Mallory is sure this is just what the doctors have been waiting for."

W E S N O C A

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ASHEVILLE, NORTH CAROLINA

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Special treatment facilities for those who need to be away from their homes and businesses. No confining walls or restrictions of a general hospital or conventional type institution.

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Medical Director Superintendent



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A rehabilitation center for the diagnosis, treatment and rehabilitation of neuromuscular diseases.

Completely equipped for treatment of all physical rehabilitation problems.

Inpatients and outpatients accepted.

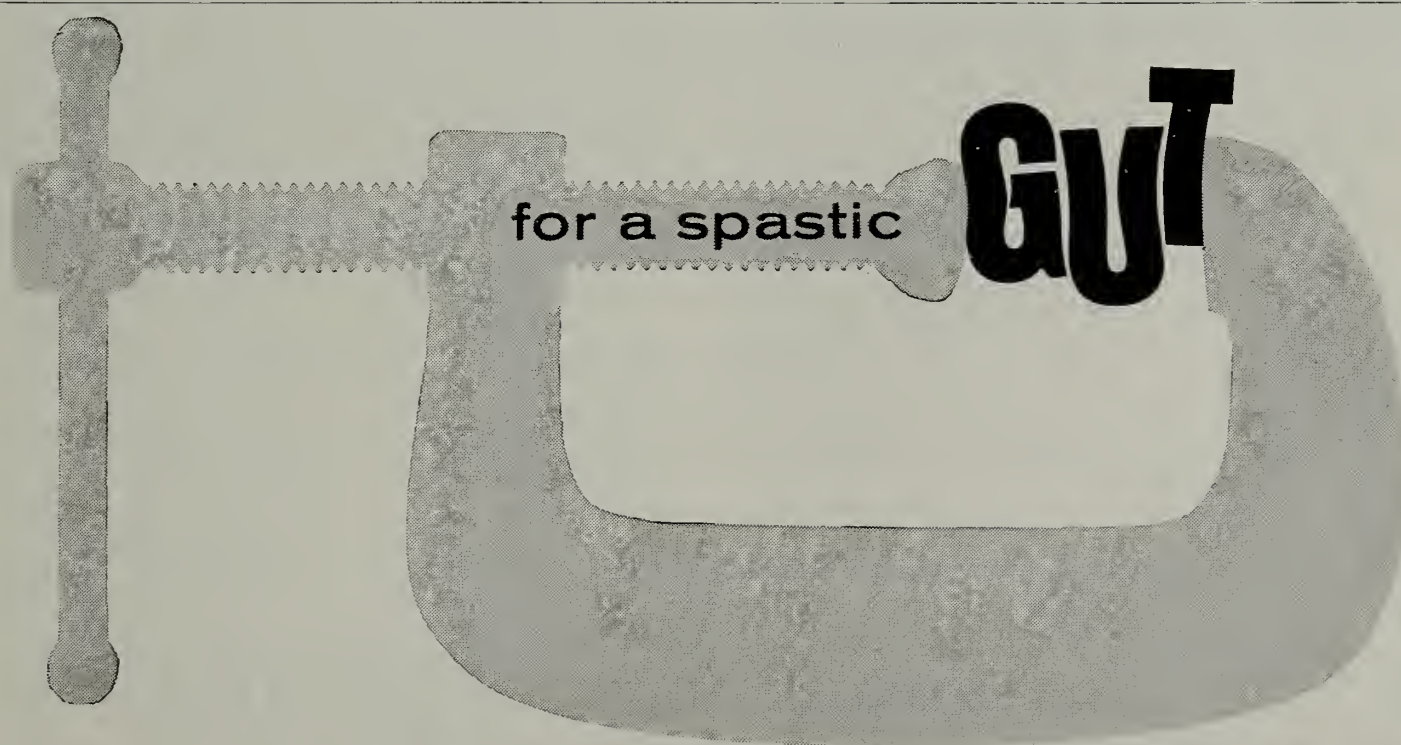
A brace shop manned by trained personnel has been established.

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integrated relief...
mild sedation
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TABLETS (yellow, coated), each containing 50 mg. Trasentine® hydrochloride (adiphenine hydrochloride CIBA) and 20 mg. phenobarbital.

2/2228M

MEDICAL HORIZONS TV Monday P.M.
Sponsored by CIBA

ABC-TV

Local Cooperation Sought in Project To Interest Students in Science

Cooperation in the promotion of Science Fairs and Science Days being held in Ohio high Schools this Spring affords county medical societies an unusual opportunity for community service and good public relations.

The Science Fairs Project is sponsored by the Science Clubs of America, with 15,000 clubs in the United States, including about 750 in Ohio schools. Its objective is to stimulate students to take a more active interest in the study of science, to provide a proper means of recognition to young scientists, to allow them to see what others are doing in science and to arouse public interest in the scientific ability of young people.

Finalists in regional or local area fairs will be invited to participate in the seventh National Science Fair to be held at Oklahoma City, Okla., May 10-12, 1956. The American Medical Association will present special citations to the two high school students with the best exhibits on medical research, general health or physical fitness at the National Science Fair. In addition, the two winners will be invited to display their exhibits in the scientific exhibit at the AMA's annual meeting June 11-15 in Chicago.

Also interested in developing scientific talent among high school students, the Ohio Academy of Science is the sponsoring organization for Science Day, which is not affiliated with any national project. However, last year 2,268 Ohio high school students participated in District Science Days and 249 students who had previously displayed exhibits at district meetings, took part in the State Science Day. The State is divided into seven districts with centers at the following colleges and universities: Bowling Green, Kent State, Ohio State, Muskingum, Miami, Ohio and Wittenberg. Students who receive a "superior" rating for their exhibits at the district meetings will be permitted to enter the State Science Day to be held at Wittenberg College, Springfield, April 20.

Information concerning the Science Fairs and Science Days projects has been furnished the presidents of the state's county medical societies by the Departments of Public Relations of the American Medical Association and the Ohio State Medical Association.

Fort Steuben

Subject for discussion at the February 14 meeting of the Fort Steuben Academy of Medicine in Steubenville was "Disorders of the Cervical Intervertebral Discs." Speakers were Dr. Frank H. Mayfield, of the Department of Neurosurgery, University of Cincinnati, and Dr. William Mikita, of Steubenville.

Physicians Invited To Offer Advice on Small Hospitals' Diet Manual

Here is an opportunity for physicians who are interested in the subject to offer practical advice and suggestions on the preparation of a diet manual suitable for use in small hospitals and nursing homes.

The Ohio Department of Health, in cooperation with the Ohio Dietetic Association, has made tentative plans for the preparation of a simplified diet manual suitable for use by food service personnel of small hospitals and nursing homes not under the supervision of a qualified dietitian.

Dr. Ralph E. Dwork, director of the Ohio Department of Health, has requested the assistance of the Ohio State Medical Association in the preparation of the manual.

Below is the tentative table of contents for the manual now under consideration. Physicians, especially those who have patients in small hospitals and nursing homes without a dietitian, are invited to comment. For example, should additional diets be included? Should changes be made in nomenclature? Are there other types of information which should be included in the manual?

Physicians are requested to direct their comments to the Headquarters Office of the Ohio State Medical Association, 79 East State Street, Columbus 15, Ohio, from which they will be forwarded to Dr. Dwork.

The proposed table of contents follows:

Introduction	Ulcer diet 2 (small feedings, six meals)
Normal diets	Ulcer diet 3 (three meals)
Diet for the older person	Low Fat
Children's diets	Diabetic diet
Infant	Reduction Diet
Pre-school	1500 calories
School age	1200 "
Teen-age	1000 "
Normal pregnancy and lactation	Low Sodium
Soft diets	900 mg. sodium
Regular soft	400 mg. "
Dental soft	200 mg. "
Liquid diets	Recommended Dietary Allowances
Full liquid	Best Sources of Food Nutrients
Clear liquid	References on Nutrition and Diet Therapy
Tube feeding	How to order diets
Low Residue	
Ulcer diets	
Ulcer diet 1 (milk and cream)	

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Cincinnati Heart Group To Present Program of Seminars March 29

The Cincinnati Chapter of the American Heart Association will present "Round Tables on Heart Diseases" on Thursday, March 29, at the Netherland Plaza Hotel. This group of seminars is a part of the professional education program of the Heart Association of Greater Cincinnati. It will be of particular interest to medical specialists and to general physicians, and has been approved for six hours of Category II credit by the Ohio Academy of General Practice.

The program is as follows:

MORNING SESSION

Chairman: Dr. George Schwemlein

9:00 - 9:30—Registration

9:30 - 10:10—Highlights of Rheumatic Disease

Prevention of Rheumatic Fever—Dr. Robert Lyon

Treatment—Dr. Carl Wehl

Discussion—Moderator, Dr. Harry Shirkey

10:10 - 10:50—Adrenal Steroids and the Heart

Natural Disturbances—Dr. James Agna

Iatrogenic Disturbances—Dr. Mark Upson

Discussion—Moderator, Dr. V. Esselborn

11:00 - 11:50—The Surgeon Remakes the Heart

Congenital Lesions—Dr. Louis Buente

Mitral Disease—Dr. Elmer Maurer

Other Conditions—Dr. James Helmsworth

Discussion—Moderator, Dr. Johnson McGuire

12:00 - 1:25—Luncheon; Host, Dr. Harold Kotte;

Remarks—"The Doctor, the Public and the Heart Association."

AFTERNOON SESSION

Chairman: Dr. Henry Ryder

1:30 - 2:10—CPC

Case Editor—Dr. Mark Upson

Dr. M. A. Blankenhorn

Dr. Philip Wasserman

2:10 - 3:05—Infarction of the Heart; Complications

Arrhythmias—Dr. Sanford Courter

Shock and Failure—Dr. Arnold Iglauer

Thrombo-embolism—Dr. Helen Glueck

Discussion—Moderator, Dr. Daniel Rivers

3:15 - 3:30—High Blood Pressure

Control by Drugs—Dr. Murray Sheldon

Surgical Treatment—Dr. Leonard Gottesman

Management of Complications—Dr. Tom Levin

Discussion—Moderator, Dr. Robert Woolford

4:15 - 4:30—Disease of the Arteries

Medical Management—Dr. Clayton Sikes

Surgical Innovations—Dr. John Cranley

Discussion—Moderator, Dr. Bernard Schwartz.

On February 2 the Doctors' Orchestra of Akron gave the first of 10 concerts on its schedule for the 30th season. The orchestra was organized in 1926 by Dr. A. S. McCormick, its director. It is composed of approximately 35 persons.

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was successfully
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*Lawrence, W. E.; Kahn, S. S., and Riser, A. B.:
South. M. J. 47:105, 1954.

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In Memoriam . . .

George Creed Bishop, M. D., St. Bernard (Cincinnati); University of Cincinnati College of Medicine, 1924; aged 54; died January 15; member of the Ohio State Medical Association and the American Medical Association. Dr. Bishop took internship and residency work at Johns Hopkins Hospital and Good Samaritan Hospital before he began practice in the Cincinnati area. He was a member of Alpha Omega Alpha, a member of the Catholic Church and the Knights of Columbus. Surviving are his widow, two sons, and his stepmother.

John William Brobst, M. D., Columbus; Starling Medical College, Columbus, 1902; aged 77; died January 29; member of the Ohio State Medical Association and the American Medical Association. Dr. Brobst served 53 years in the medical profession, virtually all of it in Columbus, and had been recognized with the 50-Year Pin and Certificate of the Ohio State Medical Association. A veteran of World War I, during which he served as a captain in the Medical Corps, he was a member of the American Legion. Other affiliations included membership in the Lutheran Church and the Masonic Lodge. Surviving are his widow, a daughter and two sisters.

John B. Casello, M. D., Cincinnati; University of Michigan School of Medicine, 1892; aged 86; died November 7; former member of the Ohio State Medical Association and the American Medical Association. Dr. Casello practiced medicine in Cincinnati for more than 60 years and was honored in 1950 by the Academy of Medicine of Cincinnati by being presented the 50-Year Pin and Certificate of the Ohio State Medical Association. In the same year his friends and patients honored him with a testimonial dinner and presented him a commemorative plaque. Dr. Casello is survived by his widow, a daughter and two sons.

Martin S. Collins, M. D., Springfield; Baltimore Medical College, University of Maryland, 1908; aged 75; died January 18 in Florida where he was spending the winter; member of the Ohio State Medical Association and the American Medical Association. Dr. Collins served all of his professional career in Clark County, having practiced at North Hampton until 1923 when he moved to Springfield. He retired from active practice 10 years ago. He was a member of the Lutheran Church, Knights of Pythias and the Masonic Lodge. Surviving are his widow, two sons, four sisters and a brother, Dr. James T. Collins, of Cleveland.

Dana W. Collison, M. D., Columbus; University of Maryland College of Physicians and Surgeons, 1886; aged 98; died February 6; member of the Ohio State Medical Association, the American

Medical Association and the Ohio Academy of General Practice. Dr. Collison began his practice in Glouster and moved to Columbus in 1891, continuing in practice until about eight years ago. He was a former physician at the Ohio State Penitentiary and during World War I served as a captain in the health service. He was a member of the Masonic and Elks Lodges, the National Sojourners organization, the McGuffey Society and the Methodist Church. A son and a daughter survive.

Lowell A. Erf, M. D., Philadelphia, Pa.; Ohio State University College of Medicine, 1931; member of the Pennsylvania State Medical Association. Formerly of Columbus, Dr. Erf was a member of the faculty of Jefferson Medical College, where he continued his research in hematology. His widow survives.

Roland Haven Good, M. D., Van Wert; Ohio State University College of Medicine, 1925; aged 55; died January 24; member of the Ohio State Medical Association and the American Medical Association. A native of Chicago, Dr. Good lived most of his early life in Van Wert. He returned there upon completion of his medical training in 1927 to practice in association with his father, the late Dr. B. L. Good. During World War II, he served with the Army Medical Corps and attained the rank of major. He was a member of the American Legion, the Methodist Church, the Elks Lodge, the Willow Bend Country Club and a 32nd Degree Mason. Survivors include his widow, two daughters and a brother.

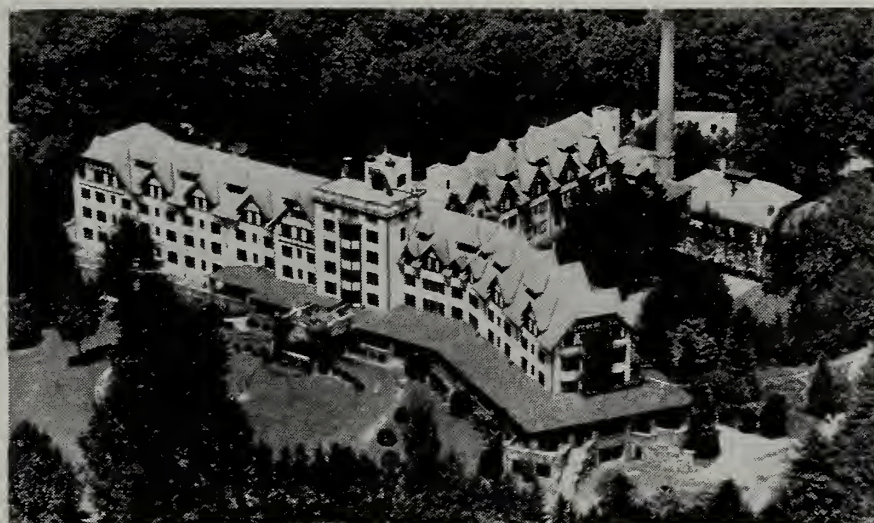
Henry P. Hart, M. D., Massillon; Western Reserve University College of Medicine, 1913; aged 71; died January 22, the innocent victim of a berserk man while on a professional call; member of the Ohio State Medical Association and the American Medical Association. Dr. Hart had been a practicing physician in Massillon for more than 40 years. Surviving are his widow, a son and a daughter.

Edgar Ward Hill, Sr., M. D., Marietta; Starling Medical College, Columbus, 1887; aged 94; died January 7; former member of the Ohio State Medical Association. A native of Washington County, Dr. Hill completed 51 years of practice there before he retired in 1938. He had since been honored with the 50-Year Pin and Certificate of the Ohio State Medical Association. He was active in a number of organizations, among them several Masonic bodies, the Lions Club and the Congregational Church. A granddaughter and a great-granddaughter survive.

Kendall Owen Kennedy, M. D., Utica; Ohio State University College of Medicine, 1937; aged 45; died January 16; member of the Ohio State

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Medical Association and the American Medical Association. Dr. Kennedy began his practice in Ashley in 1937 and moved to Utica in 1948. He was a veteran of World War II, having served as a battalion surgeon. Religious affiliation was with the Seventh-Day Adventist Church. Surviving are his widow, a son, a daughter and his father.

Edward D. King, M.D., North Hollywood, California; Ohio-Miami Medical College, Cincinnati, 1912; aged 67; died January 15. Dr. King practiced for many years in Cincinnati before he moved to California about 10 years ago. Survivors include his widow, three sons, two brothers, and two sisters.

Edward J. McGrath, M.D., Cincinnati; University of Cincinnati College of Medicine, 1932; aged 49; died January 19; member of the Ohio State Medical Association, the American Medical Association; diplomate of the American Board of Surgery; fellow in surgery of the National Research Council; member of Central Surgical Association, the Society of University Surgeons, the American Society of Thoracic Surgeons, and other professional organizations. Associate dean of the University of Cincinnati College of Medicine and member of the Cincinnati Board of Health, Dr. McGrath was particularly active on the staffs of Children's Hospital and Dunham Hospital. He was a member of the Literary Club and the Historical and Philosophical Society. Surviving are his widow, a son and a daughter.

Clovis L. McKibben, M.D., Monte Vista, Calif.; University of Cincinnati College of Medicine, 1924; aged 58; died January 21; former member of the Ohio State Medical Association; Fellow of the American College of Physicians. Dr. McKibben practiced for about 17 years in Toledo before he retired in 1942 and moved to California. He was a member of the Masonic Lodge, Lambda Chi Alpha and Phi Chi and an elder in the Presbyterian Church. Surviving are his widow, his mother and a sister.

Hans Walter Mamlok, M.D., Akron; Medical School, Bonn, Germany, 1933; aged 47; died January 20; member of the Ohio State Medical Association and the American Medical Association. A native of Germany, Dr. Mamlok began practice in Akron in 1939. He served in the U.S. Army during World War II. Surviving are a brother, Dr. Eric Mamlok, of Staten Island, New York, and his father in Uruguay.

Elmer Warren Smith, M.D., Columbus; Ohio Medical University, 1902; aged 83; died January 24. Dr. Smith practiced medicine in Columbus many years ago, retiring about 1928. A brother and a sister survive.

William Terrence Sullivan, M.D., Kelleys Island; Kentucky School of Medicine, Louisville, 1895; aged 87; died January 8; member of the Ohio State Medical Association and the American

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Medical Association. Dr. Sullivan practiced on Kelleys Island from 1920 to 1924 and returned there in 1948 after an extended practice in Clarksville. He practiced for many years prior to 1920 in West Mansfield. With a total of more than 60 years of medical practice, Dr. Sullivan had received the 50-Year Pin and Certificate of the Ohio State Medical Association. A daughter survives.

Charles L. Tinker, Sr., M. D., New Philadelphia; University of Cincinnati College of Medicine, 1909; aged 73; died January 14; member of the Ohio State Medical Association, the American Medical Association. A native of New Philadelphia, Dr. Tinker had been a practicing physician in the area for 45 years. In addition to his medical practice, he was active in numerous civic, fraternal and other community affairs. He had been elected an honorary life member of the medical staff at Union Hospital. He was an honorary life member of the Elks Lodge and a charter member of the local group of the American Federation of Musicians. Other affiliations included the Masonic Lodge, the Moose and Eagles Lodges, the Fraternal Order of Police, the Yacht Club, the National Rifle Association, the American Bowling Congress, and the Lutheran Church. Surviving are his widow, a son and a daughter.

Charles Jesse Wehr, M. D., Bellevue; Western Reserve University School of Medicine, 1901; aged 80; died January 7; member of the Ohio State Medical Association and the American Medical Association. A practicing physician for more than a half century, he had been honored with the 50-Year Pin and Certificate of the Ohio State Medical Association. He was a member of the Lutheran Church, the Masonic Lodge, Woodmen of the World, the local Book Club, and the Sandusky Stamp Club. He also was active in community affairs, having served on the local board of education and the city council. Surviving are his widow, two daughters and four sons.

Anna Blattenberg Yoder, M. D., Smithville; Cleveland College of Physicians and Surgeons, 1906; aged 80; died January 30; former member of the Ohio State Medical Association. A native of Smithville, the former Anna Blattenberg married Homer M. Yoder in 1903 and the two went through medical school together and practiced together in the village. In 1954 the citizens of Smithville honored the Doctors Yoder with a buffet supper. She was a member of the Methodist Church and the local chapter of the DAR; she was active also in Cub Scout work. Her husband, Dr. Homer Yoder, survives.

Federal Trade Commission has filed a complaint against Wayne School, Inc., Chicago, charging deceptive advertising of its correspondence course in practical nursing.

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Activities of County Societies . . .

First District

(COUNCILOR: CHARLES T. ATKINSON, M. D.,
MIDDLETOWN)

HAMILTON

A symposium on Painful Joints composed the program for the January 17 meeting of the Academy of Medicine of Cincinnati. Guest speakers for the program were Dr. Joseph Lee Hollander, associate professor of medicine, University of Pennsylvania; and Dr. William D. Robinson, professor of internal medicine, and consultant for the Rackham Arthritis Research Unit, University of Michigan, Ann Arbor. Local discussant was Dr. Nathan R. Abrams, assistant clinical professor, University of Cincinnati College of Medicine.

On February 7 the subject, "Problems of Therapy in Liver Disease," was discussed by Dr. Frank M. Hanger, professor of medicine, Columbia University.

On February 21 the Academy had as guest speaker Dr. Philip F. D. Seitz, Institute for Psychoanalysis, Chicago, who spoke on "Anxiety."

Second District

(COUNCILOR: G. A. WOODHOUSE, M. D.,
PLEASANT HILL)

DARKE

"Treatment of Head Injuries as Related to General Practice," was the subject of discussion for the February 21 meeting of the Darke County Medical Society. Speakers were Dr. N. R. Hollister and Dr. Philip Andrews, both of Dayton.

GREENE

Dr. R. W. Kissane, of Columbus, spoke on "Atrial Fibrillation" at the meeting of the Greene County Medical Society on February 9 in Greene Memorial Hospital. A coffee hour was conducted by the Woman's Auxiliary.

MIAMI

The Miami and Shelby County Medical Societies met jointly on February 9 for luncheon and a program at the Piqua Country Club. The speaker was Dr. Samuel Saslaw, assistant professor of medicine, Ohio State University, who discussed "Commonly Overlooked Infectious Diseases." Dr. Saslaw heads the section on communicable diseases at the OSU Health Center.

MONTGOMERY

The executive council of the Montgomery County Medical Society has approved establishment of a human tissue bank which would provide graft materials for Dayton hospitals.

To set up the project the Medical Foundation of Dayton and Montgomery county has approved

a grant of \$3,000 which would provide equipment, such as refrigerators, deep freeze, a dermatome and other items.

The materials for grafts—skin, blood vessels, bone, muscle, cartilage, eye parts and nerve tissue—would be collected through autopsy procedures.

At present local hospitals have limited supplies of some tissues but a special committee, headed by Dr. Charles G. Lovingood, determined that a need existed for such a homograft bank in the Dayton area.

The Medical society committee report on the bank said the unit "could be utilized by physicians routinely and would be a vital source of tissues in a disaster where multiple cases would be cared for on an emergency basis." It said the fact that Good Samaritan, Miami Valley and St. Elizabeth hospitals have excellent pathology departments places the county in an advantageous position for the operation of a successful bank.

Under the proposal, the medical society would administer the bank and allot tissues to institutions needing them. The nearest such bank at present is in Louisville.

The committee making the study included Drs. J. O. Beavis, W. G. Eckman, A. E. Fouke, N. R. Hollister, Charles E. O'Brien, J. C. Schumacher, P. A. Weisman and Robert E. Zipf.

The medical foundation which made the grant is a private, non-profit corporation financed by gifts from individuals and interested organizations. It was founded in 1951. President is Dr. Harold M. James.—*Dayton News*.

* * *

The General Practice Section of the Montgomery County Medical Society met on February 15 at Suttmiller's Restaurant for luncheon. The speaker was Dr. Philip Andrews whose topic was, "The Use of the EEG in General Practice."

The Dayton Obstetrical and Gynecological Society met on February 15 at the Van Cleve Hotel for dinner and a meeting. Speaker for the occasion was Dr. Virginia Apgar, clinical professor of obstetrical and gynecological anesthesia, Columbia Presbyterian Medical Center, whose topic was, "Obstetrical Analgesia and Anesthesia (Including the Pediatric Problems Involved)."

Fourth District

(COUNCILOR: PAUL F. ORR, M. D., PERRYSBURG)

LUCAS

The January program of the Academy of Medicine of Toledo contained the following features:

Annual Academy Meeting, Commodore Perry Hotel, January 11.

Medical Section meeting, January 20—"The

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Present Status of the Use of Corticosteroids in Allergic Disease," Dr. John Sheldon, professor of medicine, University of Michigan.

Surgical Section, January 26 and 27—Cancer Symposium by members of the staff of Memorial Center, New York City.

On January 26 and 27 the Surgical Section of the Academy sponsored a Cancer Symposium, presented by the Memorial Center for Cancer and Allied Diseases of New York City. The following physicians of the Center presented the subject from the phases indicated: Dr. J. J. Nickson, radiotherapy; Dr. Emerson Day, office procedure; Dr. David Karnofsky, the leukemias and lymphomas; Dr. R. W. Rawson, endocrinologic control; Dr. Gordon McNeer, metastatic pattern of stomach cancer; Dr. William Daniel, surgical treatment of recurrent carcinoma of the cervix.

Fifth District

(COUNCILOR: GEORGE W. PETZNICK, M. D., CLEVELAND)

CUYAHOGA

The Academy of Medicine of Cleveland regular meeting of January 20 featured a program on Upper Gastrointestinal Bleeding. The following subjects were discussed:

"Diagnosis of Upper Gastrointestinal Bleeding—Use of Immediate X-Ray, Gastroscopy, etc," Dr. William Abbott.

"Use of the Sengstaken-Blakemore Tube in the Differential Diagnosis of Upper Gastrointestinal Bleeding and in the Treatment of Bleeding Esophageal Varices," Dr. Philip F. Partington.

"Results of Medical Management of Bleeding Peptic Ulcers," Dr. Austin Chinn.

"Technical Consideration in the Surgery for Bleeding from the Stomach and Duodenum," Dr. Stanley Hoerr.

Panel Discussion, with Dr. Hoerr as moderator.

Following a social hour and dinner, Dr. John D. Stewart, University of Buffalo, spoke on the subject, "Bleeding from the Stomach and Duodenum."

Sixth District

(COUNCILOR: CARL A. GUSTAFSON, M. D., YOUNGSTOWN)

MAHONING

A gavel made by a colleague was given Dr. Gabriel E. DeCicco of 207 Mill Creek Drive January 18 when he became president of the Mahoning County Medical Society.

The gavel, tooled and engraved by Dr. A. E. Brant in his home woodwork shop, was presented Dr. DeCicco by Dr. Ivan C. Smith, outgoing president, at the society's installation banquet at Youngstown Country Club. More than 120 doctors attended.

Dr. S. S. Badal, who has practiced medicine

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in the Youngstown area for 50 years, was awarded a 50-year pin and certificate by the Ohio State Medical Association. Dr. Kenneth Camp of Lowellville paid tribute to Dr. Badal who was unable to be present.

Dr. John Heberding and Dr. W. W. Ryall, 50-year veterans, were among members at the banquet. A social program followed the dinner and business meeting.

Dr. DeCicco assumes the presidency following long years of service to the society and the medical profession in Mahoning County. He served as secretary of the society for six years and was chairman of the annual postgraduate day for two years.—*Youngstown Vindicator* per C. K. Walter, M.D., Correspondent.

SUMMIT

Dr. Ray A. Van Ommen, of the Division of Medicine, Cleveland Clinic, was guest speaker for the January 3 meeting of the Summti County Medical Society. He discussed, "Treatment and Prophylaxis of Bacterial Endocarditis." Dinner was held at the Akron City Club followed by the meeting in the Akron General Hospital Auditorium.

Seventh District

(COUNCILOR: ROBERT HOPKINS, M. D., COSHOCTON)

BELMONT

The Belmont County Medical Society with the Auxiliary met on January 19 at the Belmont Hills Country Club for dinner and a social evening.

Tenth District

(COUNCILOR: E. H. ARTMAN, M. D., CHILLICOTHE)

FRANKLIN

The Columbus Academy of Medicine had as guest speaker for the January 16 meeting Dr. H. Houston Merritt, Columbia University who spoke on the subject, "Epilepsy and Its Diagnosis." Dr. Merritt is professor of neurology at Columbia and director of the service of neurology at the Neurological Institute of Presbyterian Hospital in New York.

Eleventh District

(COUNCILOR: H. T. PEASE, M. D., WADSWORTH)

MEDINA

The regular meeting of the Medina County Medical Society was held at McKee's Restaurant at LeRoy on February 16 with Judge Cloyd W. Derhammer as the speaker. Judge Derhammer discussed adoption, commitment to state hospitals and entrance to the Medina County Home.

The meeting in March will be on the subject,

narcotics and the regulations both state and national.

RICHLAND

Members of the Richland County Medical Society met at Mansfield General Hospital, Thursday, January 19, 1956. Dinner was served at the hospital, after which a business meeting was held, with Dr. P. O. Staker, President, presiding.

Due to the severe weather, the speaker who was scheduled to address the meeting was unable to reach Mansfield. The program consisted of viewing three films which had been selected by the program committee—C. F. Curtiss, M.D., Secretary-Treasurer.



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Treasurer—Mrs. Herbert Van Epps, 425 E. 15th St., Dover

Past-President—Mrs. A. Paul Hancuff, 3551 Maxwell Road, Toledo

CHAMPAIGN

Champaign County Medical Society and Auxiliary held their annual Christmas party at the Urbana Country Club. During the evening, Dr. V. G. Wolfe was honored with a 50-Year pin which was presented to him by Dr. George Woodhouse of Pleasant Hill, Second District councilor for the Ohio State Medical Association.

Dr. Mark Houston wrote a poem in honor of Dr. Wolfe and read it before the assembled guests.

The Woman's Auxiliary held a luncheon meeting at the Airport in Urbana January 6. Dr. Kurt Becker, Public Health Commissioner for Champaign and Miami Counties, spoke to the group using the topic, "Public Health."

ERIE

Twin teas were given at Providence and Good Samaritan Hospitals simultaneously by the Woman's Auxiliary. The president of the Woman's Auxiliary to the Erie County Medical Society, Mrs. H. E. Snedden, attended the tea held in the Doctors' Lounge at the Good Samaritan Hospital. Mrs. W. C. Seiler, first vice-president of the Auxiliary was also present.

At Providence the tea was held in the cafeteria, with Mrs. W. P. Skirball, 2nd vice-president of the medical auxiliary and Mrs. Lester Parker of the Auxiliary program committee present.

FAIRFIELD

Husbands of members of the Woman's Auxiliary to Fairfield County Medical Society were guests at the annual Christmas dinner party on December 8. Lancaster Country Club was the scene of the gala affair given by the Auxiliary. The committee arranging the party was composed of Mrs. A. B. VanGundy, Mrs. W. D. Nusbaum, Mrs. G. F. Jones and Mrs. R. S. Bode.

HAMILTON

The Woman's Auxiliary to the Hamilton County Medical Society reports that its Future Nurse Clubs are meeting with instantaneous success in the high schools of Cincinnati. These clubs are now being organized in the schools, and the lively interest and sparkling enthusiasm on the part of the student is most encouraging.

Varied and colorful programs, field trips to the city's hospitals and participation in Health Exhibits have been arranged for the high school girls by Mrs. William Lippert, chairman, and the members of her active committee.

A dynamic Speakers' Panel, comprised of representatives from the many fields of Nursing, is under the direction of Mrs. Frank Stevenson and is proving to be very popular.

The originator of the Future Nurses Club idea in Cincinnati is Western Hills High School, which has organized such a group to unite all girls interested in nursing as a career and to give them the opportunity of becoming more familiar with the duties of a nurse and of the different schools of nursing.

HARDIN

Sister Theodore was official hostess for the local Sisters of Charity December 13 when they gave their annual Christmas dinner party for members of the Hardin County Medical Society, their wives and friends, in the dining room at San Antonio hospital.

HURON

On December 9, the home of Dr. and Mrs. T. H. Smith in New London was the scene of a

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*Krantz, J. C., Jr., and Carr, C. J.: *The Pharmacologic Principles of Medical Practice*, ed. 3, Baltimore, The Williams and Wilkins Company, 1954, p. 998.

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Christmas party for the Huron County Medical Auxiliary. Under the tree had been placed many colorfully wrapped gifts for Huron County's handicapped children.

It was decided that the Auxiliary present an application form to one or two young ladies for a loan if interested in nursing as a profession.

LUCAS

Bob Feller of the Cleveland Indians, state chairman of the March of Dimes, spoke at the kickoff tea for the fifth annual Mothers' March on Polio.

Captains, co-captains and lieutenants of the various elementary school districts and township schools were introduced, and kits for the Mothers' March on Polio were distributed.

Board members of the Woman's Auxiliary to the National Foundation of Infantile Paralysis were guests at the tea.

Sixty-two Lucas County members contributed food to a bake sale held at the October meeting. Profit for the Program Committee, derived from the successful sale was \$100.50.

The Auxiliary Community Chest Team went over the top in achieving their 1955 goal.

The Future Nurses Clubs were guests of the Auxiliary in November. There were 250 present.

Sixteen Auxiliary members were interviewed on WSPD 7-V Hospitality House program. The purpose of the program was to acquaint the TV audience with the Auxiliary, its functions and objectives.

OTTAWA

Auxiliary to the Ottawa County Medical Society met at the home of Dr. and Mrs. Kraft Ritter for their Christmas party.

RICHLAND

Mrs. Dale Kinney, society and woman's page editor of the *Mansfield News-Journal*, spoke to the Woman's Auxiliary to the Richland County Medical Society following luncheon in December at the Women's Club. Mrs. Paul Lee, program chairman, introduced Mrs. Kinney, whose subject was "Publicity Pointers." Mrs. Kinney explained the basic rules of reporting events in order to achieve a well-written news story.

The Golden Age Club of Friendly House gave a musical program for the Woman's Auxiliary to the Richland County Medical Society at a Christmas tea in December, held at Friendly House.

SCIOTO

The home of Mrs. Clyde M. Fitch was the scene of the Christmas meeting of the Woman's Auxiliary of Scioto County Medical Society.

At a short business meeting, plans were made to sponsor a luncheon-style show March 1 at the Elks City Club auditorium to raise money

Cook County Graduate School of Medicine

INTENSIVE POSTGRADUATE COURSES

STARTING DATES — SPRING 1956

SURGERY—Surgical Technic, two weeks, Apr. 2, Apr. 16. Surgical Anatomy & Clinical Surgery, two weeks, June 18. Surgery of Colon & Rectum, one week, Apr. 9, May 7. General Surgery, two weeks, Apr. 23. Basic Principles in General Surgery, two weeks, Apr. 9. Thoracic Surgery, one week, June 4. Esophageal Surgery, one week, June 11. Breast & Thyroid Surgery, one week, June 18. Gallbladder Surgery, ten hours, Apr. 9, June 25. Fractures & Traumatic Surgery, two weeks, June 18. Varicose Veins, ten hours, Apr. 30, June 18.

GYNECOLOGY—Office & Operative Gynecology, two weeks, Apr. 16, June 18. Vaginal Approach to Pelvic Surgery, one week, Apr. 30, June 11.

OBSTETRICS—General & Surgical Obstetrics, two weeks, May 7.

MEDICINE—Internal Medicine, two weeks, May 7. Electrocardiography & Heart Disease, two week basic course, Mar. 12. Gastroenterology, two weeks, Apr. 23. Dermatology, two weeks, May 7.

RADIOLOGY—Diagnostic X-Ray, two weeks, Apr. 30. Clinical Uses of Radioisotopes, two weeks, May 7.

PEDIATRICS—Intensive Review Course, two weeks, May 14. Neurological Diseases: Cerebral Palsy, two weeks, June 18.

UROLOGY—Two-Week Course April 16. Cystoscopy, ten days, by appointment.

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for the Auxiliary nurse recruitment program. Tilene's will sponsor the spring style show.

As a Christmas project, the Auxiliary provided some new rocking chairs for the County Home.

SUMMIT

The annual Christmas luncheon of the Woman's Auxiliary of Summit County Medical Society was held in the Woman's City Club. Members of Portage County Medical Society were invited to hear Mrs. Dhu Clemenson talk on "Fun With Flowers" and the Junior Glee Club of Summit County Children's Home sang Christmas carols.

VAN WERT

Mrs. J. R. Jarvis was hostess for the January meeting of the Van Wert County Medical Auxiliary. Mrs. E. W. Burnes reported on current medical legislation, and an article on mental health by Dr. Winfred Overholser, former president of American Psychiatric Association, was reviewed by Mrs. J. Cox.

National Study Shows Where Expected Longevity Greatest

Often the opinion is heard that the healthiest people in the United States live in heavily populated areas where hospitals, physicians, and other health facilities and personnel are plentiful. Recently published data on the expectation of life, particularly at birth, in each of the 48 states for 1949-51 refute this popular notion, especially for white males. The statistical department of the Metropolitan Life Insurance Company has assisted the National Office of Vital Statistics of the Department of Health, Education, and Welfare in the preparation of life tables for each state. All the tables, including those for non-white males and females, will be published soon by the National Office of Vital Statistics.

The six states with the highest expectation of life at birth for white males for 1949-1951 were: South Dakota, 68.4 years; Nebraska, Minnesota, and Iowa, 68.2 years; Kansas, 68.0 years; and North Dakota, 67.9 years. The expectation of life at birth for white males in the United States was 66.3 years. In 1939-1941 the six leading states for white males were Nebraska, South Dakota, Minnesota, Iowa, North Dakota, and Kansas. Thus it is obvious that white males of these sparsely settled states will enjoy comparatively low mortality. The only changes apparent in the figures cited above are (1) South Dakota has replaced Nebraska as the leader, and (2) Kansas and North Dakota have exchanged ranks.

It is not possible to say that longevity will actually be greatest among the white males of these six states, because expectation of life is an actuarial computation based upon the mortality rates at all ages in three specified calendar years. This computation, strictly speaking, is not a forecast of the mortality that will prevail during the entire lifetimes of the babies born

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in each of these six states in the specified three calendar years. These favorable mortality records among white males in these six states must be attributed, in part, to the strong North European strains in the population and favorable selection factors in migration. The number of miles that many people in these states must travel to visit a physician or become a patient in a hospital might be considered a health hazard by many urban dwellers, but the people in the West North Central region of the United States have developed a way of life that makes them well adjusted to these spatial conditions.

Nebraska retained its leadership in life expectation at birth for white females with 74.0 years as compared with 72.0 years for the entire United States. Oklahoma, Florida, Iowa, Kansas, and South Dakota follow with 73.8 to 73.6 years. A more general observation is that the state variations in longevity as indicated by expectation of life at birth were less in 1949-1951 than they were in 1939-1941. The leaders in expectation of life at age 25 were South Dakota, Nebraska, and Iowa, with 46.8 years for white males. The leading states for white females at age 25 were Oklahoma, Nebraska, Florida, Arkansas, Kansas, Iowa, Texas, South Dakota, and Utah, ranging from 51.8 years to 51.1 years. The states in which the people at age 65 had the greatest expectation of life were Arkansas, Florida, and Oklahoma for white males and Florida, Arizona, Arkansas, Oklahoma, and Texas for white females.

The variations in expectation of life in 1949-1951 at these three selected ages were less marked, of course, among the nine regions than among the 48 states. The West North Central region (Minnesota, North Dakota, South Dakota, Iowa, Nebraska, Missouri, and Kansas) had the highest expectation of life for white males at birth (67.8 years) and at 25 (46.4 years), but the West South Central region ranked first at age 65 (13.4 years versus 13.3 years). For white females the West North Central region had the highest expectation of life at birth, 73.3 years; at age 25 its 50.9 years ranked it second to the West South Central region with 51.2 years, at age 65, however, it was outranked by a small margin by the West South Central, Mountain, and Pacific regions. In 1939-41, the West North Central region ranked first in expectation of life at birth, at age 25, and at age 65 for white males; and first at birth, first at age 25, and tied for second at age 65 for white females. These data for the nine regions, as well as those for the individual states, should remove all doubt about where the expectation of life is and has been the highest, particularly at birth and at age 25.—J. A. M. A., Dec. 3, 1955.

Under revised army promotion policies, physicians will be eligible for temporary promotion to the grade of major, lieutenant colonel and colonel one year sooner than other Army officers, it has been announced by Major General Silas B. Hays, the Army Surgeon General.

Report of State Medical Board For Calendar Year, 1955

The report of the activities of the State Medical Board for the year 1955, submitted to the Governor by Dr. H. M. Platter, board secretary, contained the following interesting data:

Doctors of medicine licensed in Ohio, following examination, numbered 550. A total of 389 doctors of medicine were licensed by endorsement from other states. Seventy-three osteopathic physicians qualified through examination and five through endorsement. Ninety-six limited practitioners were licensed.

Graduates in medicine who failed to qualify numbered 72. Osteopathic failures totalled 5 and limited practitioners, 176.

The board's inspectors visited 61 counties during the year, investigating 290 cases. Forty-nine cases were filed in court; six cases dismissed; cases from former years disposed of totalled, 21; cases in which convictions were secured, 31. At the end of the year 29 cases were awaiting trial. Fines assessed totalled, \$5,059.00 of which \$1,150.00 were suspended.

Cancer Conference To Be Held in Detroit

The American Cancer Society and the National Cancer Institute of the Public Health Service, Department of Health, Education, and Welfare, will jointly sponsor the Third National Cancer Conference in Detroit, Mich., June 4, 5, and 6. More than a thousand research scientists and clinicians, including many from foreign countries, are expected to attend.

The last National Cancer Conference was held in Cincinnati, Ohio, in 1952.

Copies of the conference program and advance registration cards may be obtained from the National Cancer Conferences Coordinator, American Cancer Society, 521 West 57th Street, New York 19, N. Y.

All physicians are invited to attend.

Cincinnati Physician Gives Series Of Out-of-State Lectures

Dr. M. A. Blankenhorn, professor of medicine and director of internal medicine at the University of Cincinnati College of Medicine, filled three engagements during February and early March. As guest speaker of the Henry Ford Medical Society, he presented a paper on "Diagnosis and Treatment of Disseminated Miliary Diseases of the Lung," in Detroit and conducted grand rounds at the Henry Ford Hospital.

He visited the Emory University Department of Medicine, Atlanta, Ga., to take part in the teaching program and lecture on myocarditis and myocardioidosis and on miliary diseases of the lungs.

For the three days beginning February 28 he was scheduled to serve as physician-in-residence at the Bay Pines (Florida) Veterans Administration Hospital.

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Bumbalo, T. S., Gustina, F. J.,
and Oleksiak, R. E.:
J. Pediat. 44:386, 1954.

White, R. H. R., and
Standen, O. D.:
Brit. M. J. 2:755, 1953.

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Brown, H. W.:
J. Pediat. 45:419, 1954.

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COMING MEETINGS

Ohio State Medical Association, Annual Meeting, Cleveland, April 10-12. See program in this issue for details and announcements of ancillary meetings.

American Medical Association, Annual Session, Chicago, June 12-14.

American Congress of Physical Medicine, 34th Annual Session, Atlantic City, September 9-14.

American Goiter Association, Annual Meeting, Drake Hotel, Chicago, May 3-5.

American Association of Blood Banks, September 3-5, Somerset Hotel, Boston, Mass.

Association of American Physicians and Surgeons, Annual Meeting, Deshler-Hilton Hotel, Columbus, April 5-7.

Bunts Educational Institute, Cleveland Clinic Foundation, Course on Medical Progress and Its Relationship to Dentistry, March 14-15.

Cancer Conference, Third National, American Cancer Society and National Cancer Institute, Detroit, Mich., June 4-6.

Cincinnati Chapter, American Heart Association, Round Tables on Heart Disease, Netherland Plaza Hotel, Cincinnati, March 29.

Cleveland Society of Obstetrics and Gynecology, Cleveland University Club, April 9, an invitational meeting for Ohio specialists in field.

Huron Road Hospital, Cleveland, Program on Gastroenterology, March 27-28.

1956 Industrial Health Conference, Convention Hall, Philadelphia, Pa., April 21-27.

Inter-Hospital Postgraduate Lecture Series, Maumee Valley Hospital and the Northwestern Ohio Heart Association, 3101 Collingwood Blvd., Toledo, March 29-30.

International College of Surgeons, Regional Meeting of the American Section, Madison, Wisc., April 26-28.

Ohio State Heart Association, Annual Meeting, Cleveland, April 9.

Ohio State Radiological Society, Convention, Deshler-Hilton Hotel, Columbus, May 11-13.

Ohio State University, Postgraduate Course in Ophthalmology, March 5 and 6, Ohio Union Building, OSU Campus.

Veterans Administration, Series of Wednesday evening Clinical Conferences, Cuyahoga Bldg., Cleveland.

West Virginia Chapter, American Academy of General Practice, Scientific Assembly, Daniel Boone Hotel, Charleston, April 14-15.

An estimated three per cent of all passengers flown by regularly-scheduled U. S. airlines pose a unique problem for transportation officials and physicians—unique because they are ambulatory patients who must travel as ordinary passengers.

INDEX TO ADVERTISERS

Abbott Laboratories	242 - 243
American Meat Institute	226
Ann Arbor School	323
Appalachian Hall	325
Ayerst Laboratories, Inc.	327
Bayer Company, The Div. of Sterling Drug Co., Inc.	234
Burroughs Wellcome & Co. (U.S.A.) Inc.	336 - 337
Ciba Pharmaceutical Products, Inc.	319
Cincinnati Sanitarium	229
Cook County Graduate School of Medicine	334
Davies, Rose & Co., Ltd.	326
General Foods Corporation (Sanka)	238
Harding Sanitarium	235
Hoffmann-LaRoche, Inc.	Insert between pages 244 - 245
Knox, Chas. B. Gelatine Co., Inc.	315
Lakeside Laboratories, Inc.	221, 323, 332
Lederle Laboratories	276 - 277
Liebel-Flarsheim Co.	228
Lilly, Eli, and Company	248
Luzier's, Inc.	235
MacAllister Laboratory	339
Magnetic Springs Foundation	319
Maico of Columbus	331
Mayo Clinic and Mayo Foundation	317
McMillen Sanitarium	236
Mead Johnson & Company	Back Cover
Medical Protective Company	334
National Drug Company, The	245
Neil Training School	335
New York Polyclinic Medical School	236
Northern Tri-State Medical Association	321
Pabulum Products, Division of Mead Johnson & Co.	305
Parke, Davis & Company	340 and Inside Back Cover
Pfizer, Chas. & Co., Inc.	225, 329
Picker X-Ray Corporation	241
Pogue, Mary, School, Inc.	304
Quincy X-Ray & Radium Lab.	320
Rocky Glen Sanatorium	317
Sawyer Sanatorium	244
Schering Corporation	230-231, 246 - 247
Scroggins, Clayton L., Associates (Medical-Dental Management)	240
Searle, G. D. & Company	299
Sharp & Dohme, Inc.	223, 239, 333
Silver Hill Foundation, The	322
Smith, Kline & French Laboratories	301, 313
Squibb, E. R. & Sons, Division of Olin- Mathieson Chemical Corporation	307
Stoneman Press	330
Tutag, S. J. & Company	317
Upjohn Company	227, 325
Vitamin Food Co., Inc.	335
Wallace Laboratories	237
Wendt-Bristol Company	331
Wesnoca	318
Wickhaven Sanitarium	240
Windsor Hospital, Inc.	240
Winthrop Laboratories	309
Wyeth, Inc.	311, 322

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1. Bollet, A. J., Black, R., and Bunim, J. J.: *J.A.M.A.* 158: 459, June 11, 1955.

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The Physician's Bookshelf

By JONATHAN FORMAN, M. D.

Cardiac Diagnosis; A Physiologic Approach, by Robert F. Rushmer, M. D., (\$11.50. *W. B. Saunders Company, Philadelphia 5, Pa.*). This book represents an approach to the diagnosis of heart disease based upon the function and control of the heart under both normal and abnormal conditions, emphasizing the mechanism by which the disease processes produce the various signs and symptoms. Attention is also directed to the many deficiencies in current knowledge, which can only be corrected by future investigations.

Better Health for Your Children—A Medical Guide for Parents, by Isaac Newton Kugelmass, M. D., (\$4.50. *McGraw-Hill Book Company, Inc., New York 18, N. Y.*). Unusually well organized and written in terms which the layman can readily understand, this is an extremely helpful medical guide that every parent will want for its practical and reliable advice.

Needed Research in Health and Medical Care—A Biosocial Approach—by Cecil G. Sheps, M. D., M. P. H., and Eugene E. Taylor, M. D., M. P. H., (\$5.00. *The University of North Carolina Press, Chapel Hill, N. C.*). This book had its beginning at a working Seminar on "Needed Research in Health Care" at the University in 1952. Its thesis is that to the laboratory bench, the hospital bedside, the town beset with pestilence, and the physician's office, must be added what can be learned about the relation of DISEASE to the life of the individual sick person, his family, his home, his diet, his work and play, in health and sickness, from birth to death. To carry out these investigations will call for a new administrative setup more conducive than anything we have now to creative scientific effort. A stimulating discussion for anyone interested in the etiology of health.

Reactions with Drug Therapy, by Harry L. Alexander, M. D., (\$7.50. *W. B. Saunders Company, Philadelphia 5, Pa.*). It covers both the reactions of allergic nature as well as those of intolerance or idiosyncrasy. The term "Drug" is employed conscientiously to include vitamins, hormones, serums, adjuvants, and a few of the injectable chemicals used in diagnostic work. The occurrence of such reactions as yet remains small. With the use of more such sensitizing drugs and the freer use of the older ones, this book issues a sane warning that every practicing physician should heed and hence all of us should read the book.

Vitamins in Theory and Practice, by Leslie J. Harris, (\$6.50. 4th Edition. *Cambridge University Press, American Branch, New York 22, New York*). This is a complete popular presen-

tation of all that has been learned about a round score of vitamins. We agree that "This book, an informed yet popular account, is one that everyone should use."

Hiroshima Diary: The Journal of a Japanese Physician, by Michihiko Hachiza, M. D., Translated by Warner Wells, M. D., (\$3.50. *University of North Carolina Press, Chapel Hill, North Carolina*). This is a human document of the new age in which we live. Using such scraps of paper as he could find, the author recorded daily the story of the bombing and the seven weeks that followed, with compassion, tenderness and even a touch of sly humor.

Preventive Medicine in World War II, Volume II, Environmental Hygiene, edited by Ebbe Curtis Hoff, Ph. D., M. D., (\$3.50. *Superintendent of Documents, United States Government Printing Office, Washington 25, D. C.*). This volume giving the failures as well as the achievements of the U. S. Army in a preventive way, has been admirably edited and prepared for publication in the Historical Unit of the Army Medical Service as a part of its health history. Such an evaluation as this holds many lessons for younger men as they will come to work in the field of preventive medicine.

Demonstration of Physical Signs in Clinical Surgery, by Hamilton Bailey, F. R. C. S. (\$8.00 Twelfth Edition. *Williams & Wilkins Company, Baltimore 2, Md.*). In these days when there is an overemphasis upon laboratory and other auxiliary reports, this book deserves a place in the library of every young physician and above all, in that of the hospital's Resident staff.

Psychocutaneous Medicine, by Maxmilian E. Obermayer, M. D. (\$9.75. *Charles C. Thomas, Publisher, Springfield, Ill.*). Here are brought together in one source the dermatologic and psychiatric viewpoints of cutaneous diseases.

You and Your Child's Health, by Paulette K. Hartrich, (\$3.00. *Harper & Brothers, New York 16, N. Y.*). This book teaches safety and health rules, and how to cooperate with the doctor and dentist in routine treatment and how to deal with the problem of the sick child.

Present-Day Psychology, edited by A. A. Roback, (\$12.00. *Philosophical Library, Inc., New York 16, N. Y.*). This is an original survey of departments, branches, methods, and phases, including clinical and dynamic psychology, by some forty of the leading teachers of psychology in this country. It is a definitive volume, each chap-

(Continued on page 352)

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ter having been written by an expert in his field especially for this volume.

The Shoulder and Environs, by James E. Bateman, M. D., drawings by Louise Gordon, (\$16.25. *The C. V. Mosby Company, St. Louis 3, Mo.*). A new approach to the problem of diagnosis of shoulder diseases is presented in this book. The symptoms are grouped naturally into shoulder and neck pain, predominant neck pain, and shoulder plus radiating symptoms. This arrangement separates disorders of the region as a whole. The individual lesion is then discussed in detail. Treatment is summarized at the end of each chapter, for quick reference. This book has a place in the house staff's library and in the office library of orthopedic surgeons and physicians dealing with Workmen's Compensation. The Canadian Veteran's Administration and the Workmen's Compensation Board of the Province of Ontario have cooperated wholeheartedly in furnishing material and details.

International Symposium on Cardiovascular Surgery, Henry Ford Hospital, (\$12.75. *W. B. Saunders Company, Philadelphia 5, Pa.*). This is a symposium on the physiology, diagnosis, and techniques of cardiac surgery by a distinguished and representative group of students of the heart, which was presented in a two and one-half day program to some 478 physicians.

The Life and Work of Sigmund Freud, Volume 2, 1901-1919, by Ernest Jones, (\$6.75. *Basic Books Publishing Company, New York 3, N. Y.*). This second volume of the biography of Sigmund Freud tells the story of his life and work from the turn of the century. The author had the active cooperation of the Freud family and access to thousands of private letters and unpublished records. The result depicts Freud in the full maturity of his genius.

Cancer Cells, by E. V. Cowdry, M. D., (\$16.00. *W. B. Saunders Company, Philadelphia 5, Pa.*). This book discusses the nature of the cell, its growth, its abnormalities, its chemical properties, its occurrence in animals and plants, as well as agents causing cells to become malignant. Of interest to those involved in Compensation cases is the chapter on single trauma cancers. Then there is a chapter on viruses as cancer agents, on susceptibility, hereditary agents, sex, and latency, modifying factors in cancer development, geographical frequencies, cancer prevention, cancer diagnosis, treatment, and research. A complete bibliography of 100 pages of fine print is furnished. This encyclopedic work should be on the shelf or in the library of everyone who has anything to do with cancer or cancer patients.

Breast Cancer, and Its Diagnosis and Treatment, by Edward F. Lewison, M. D., (\$15.00. *Williams & Wilkins Company, Baltimore 2, Md.*). It has been more than 25 years since a comprehensive American text on breast cancer has appeared.

In this time great progress has been made in cancer research, enough progress to justify this text, which brings together and synthesizes all the important and significant knowledge about breast cancer in a form that is practical for the clinician to apply to the individual patient.

Doctor and Patient, by Desmond O'Neill, M. D., (\$5.00. *J. B. Lippincott Company, Philadelphia 5, Pennsylvania*). This is another book, written in a highly readable form, and out of much practical experience with a great number of patients, to urge that the physician, in order to be truly effective, must know his patient as an individual. A great deal of emphasis is therefore placed upon the stresses and strains under which our patients struggle with their illness.

From Here to Maturity, by Howard H. Hamlin, M. D., F. A. C. S., (\$0.75. *Beacon Hill Press, Kansas City 3, Mo.*). This volume contains the Aycock Lectures dealing with the interaction of spirit, soul and body, in achieving maturity. It is written by a practicing surgeon and published by the International Press of the Christian Medical Association.

The Bitterness of Dawn, by Sydney S. Jacquelin, M. D., (\$3.00. *Bruce Humphries, Inc., Boston 16, Massachusetts*). This little volume contains fifty delightful poems written by a retired physician who has also enjoyed a literary career.

Radiographic Atlas of the Skeletal Development of the Knee, by S. I. Pyle, Ph. D., and Normand L. Hoerr, Ph. D., M. D., (\$4.25. *Charles C. Thomas, Publisher, Springfield, Ill.*). Written as a standard reference for the maturation of the knee joint, this atlas shows the changes produced by growth of the knee joint, by a single radiograph.

International Lectures on Police Science, by George Horace Hatherill, O. B. E., Commander, Criminal Investigation Department, New Scotland Yard, London, England, (\$2.50. *Western Reserve University Press, Cleveland 6, Ohio*). These lectures were presented at the second Institute of the Law-Medicine Center of the University, in cooperation with the Cuyahoga County Coroner's Office and Laboratory on June 20-25, 1955. These lectures are of interest to students of law enforcement and to all law enforcement professional personnel.

How to Face the Change of Life with Confidence, by Rev. Fred B. Trevitt, Th. D., and Freda Dunlop White, (\$2.50. *Exposition Press, New York 10, N. Y.*). Here a wise and witty lady and a young Presbyterian clergyman have joined together to produce a little book of advice. They do quite well in debunking many of the illusions, superstitions and old wives' tales which have been connected with the menopause for too long a time, and they offer a positive program which recognizes that change of life should be, and usually is, perfectly natural.

The Ohio State Medical Journal

Published under the direction of The Council for and by the members of The Ohio State Medical Association, a scientific society, non-profit corporation, with a definite membership, for scientific and educational purposes.

Vol. 52

April, 1956

No. 4

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The Dizzy Patient

CHARLES E. KINNEY, M. D.

THERE is probably more confusion about the diagnosis and treatment of the patient with a complaint of "dizziness" than with any other presenting complaint. This misunderstanding arises from:

1. Misuse of terms associated with this complaint.
2. The fact that these patients are cared for by the family doctor, the internist, the otologist and the neurologist. It is inevitable that each of these different groups will have a different viewpoint and approach.
3. A great number of the patients with these complaints will have spontaneous remissions to a fairly normal state of being without any treatment whatsoever; therefore, the true evaluation of therapeutic procedures is very difficult.

It should be possible within the scope of this paper to clear up most of the confusion caused by the misuse of terms. An attempt will be made to present a diagnostic approach to these cases which outline can be followed by any one of the medical groups mentioned before. At the outset, it will have to be admitted that the therapy in these cases is still pretty much on the trial and error basis.

There is one exception to this last statement. No matter what the diagnostic classification of any one given case may be, an optimistic approach to the problem by the doctor in charge followed by a favorable prognosis is always effective treatment. I am earnestly certain that many of the cure-alls of the past, such as Eusta-

The Author

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chian tube bouginage, have had their main virtue in the promise that was given along with the treatment.

HISTORY MOST IMPORTANT

Now as to terms. There is no Latin or Greek antecedent to the word *dizziness*. It is derived from an Anglo Saxon word that goes back at least 600 years. This word is *dizzy* and it was defined as "foolish," or "stupid." On the other hand, *vertigo* came to us from the Latin word *vertere* meaning, "to turn." These patients may have either the sensation of turning themselves or surrounding visible objects turning around the patient. Now we see that a patient with dizziness may or may not have vertigo but that all patients with vertigo are dizzy.

It is most obvious, therefore, that any approach to a satisfactory answer in these cases must start with a detailed history. In table 1, I have outlined what I consider to be a workable approach to the problem. You will note that the age of the patient is first. Next, a history of past or present otitis media is desirable. If the patient is over 40 years of age, any known circulatory problems should be ascertained. Following this it is very helpful to classify the case into one of sudden onset, which cases are usually the more severe ones; or as one of slow onset, which cases

are usually mild. In my experience, the classifying of these cases into either one or the other group is not as difficult as one might think and it becomes the main key to the ultimate diagnosis.

TABLE 1.—HISTORY OUTLINE FOR PATIENT WITH DIZZY COMPLAINT

-
- I. Age of patient.
 - II. History of purulent discharge from either one or both ears.
 - III. History of any known circulatory problem.
 - IV. Classify as to suddenness of onset;
 - (A) Sudden cases, usually severe.
 1. Prodromal symptoms of fullness, pressure or tinnitus.
 2. Approximate date of first attack.
 3. Any true infection preceding attack.
 4. Exactly what the patient was doing just prior to attack.
 5. Fairly exact story of length and severity of attacks.
 6. History of vertigo.
 7. History of balance and hearing between attacks.
 8. Dates, length and severity of subsequent attacks.
 - (B) Slow cases, usually mild.
 1. About when did symptoms first appear?
 2. Are the symptoms getting less or worse?
 3. Postural history.
 - a. Which position of body or head makes them worse?
 - b. What effect does movement of the head or body have?
 4. Is there an associated hearing loss or tinnitus and are these symptoms getting worse or better?
 5. Types and effectiveness of previous therapy.
-

Now comes the physical examination. I would say that the first point of such examination is a blood pressure determination. After this a careful examination of the ears is in order. No matter what the special interests of the physician in attendance, a visual examination of the ear canals and ear drums should be the next step. At this point, let me admonish that a complete examination of the ear drums is not complete until all pieces of wax or epithelial debris have been removed from the ear drums, particularly both the anterior and posterior part of Shrapnell's membrane.

If an open perforation of either one or both ear drums is found a fistula test should be done on that ear or ears. This is done by inserting an otoscope with closed air system tightly into that ear canal and alternately increasing and decreasing the air pressure within the ear canal. A positive test is when the patient has a definite increased sense of dizziness. He may even develop a combined rotatory and horizontal nystagmus.

The accurate examination of the patient's hearing is of extreme importance. There are *only* two ways that this can be accomplished. My preference is for a carefully controlled air and bone conduction audiometer evaluation. Although it is more time-consuming and a bit less accurate, a satisfactory hearing examination may be done with tuning forks. In doing such fork tests, the pitches of 500, 1,000, 2,000 and 4,000 should be used to establish an air conduction threshold, and a bone conduction—air conduction relationship for those four pitches should be made. I certainly do not consider watch tick tests nor spoken voice

tests with a noise apparatus to be at all sufficient to arrive at a diagnosis in one of these cases.

VESTIBULAR TESTS HELPFUL

If hearing tests show that the hearing is off in one or both ears, the affected ear or ears should be subjected to caloric vestibular tests. Cold stimulation is sufficient and this can be done in either one of two ways. The use of the Sir Dundast-Grant coiled copper tube is my choice. This instrument requires a tube of ethyl chloride and compressed air. The ethyl chloride is sprayed on the cloth covering of the copper tube and then air is forced through the tube under direct vision and against the posterior part of the ear drum for 30 seconds. The direction of the quick component and the severity of the resulting nystagmus is recorded at 30 second intervals until the nystagmus has subsided. A very satisfactory method of describing the severity of this nystagmus is as follows:

First Degree—Only present when the eyes are turned sharply towards the same side of the quick component. With cold stimulation, this is always to the side *opposite* from the ear being tested.

Second Degree—Nystagmus present when the eyes are directed straight ahead.

Third Degree—The nystagmus persist even when the eyes are turned sharply to the opposite side from the quick component.

Caloric tests may be done by having the patient lie down and filling the ear canal with cold water (55 to 60 degrees) and allowing it to stay there for one minute. The only evaluation of consequence is one of hypofunction, normal response, or hyperfunction. No nystagmus or only a first degree nystagmus which lasts about one minute is hypofunction. A second degree nystagmus that lasts about two minutes is considered a normal response, while a third degree nystagmus that comes on within 30 seconds, lasts four to five minutes and may be accompanied by nausea, is considered hyperfunction. Any further attempts to evaluate vestibular tests such as ascertaining which one of the canals may be more involved are very complicating and really add nothing to one's diagnosis.

There is one other examination that should be recorded particularly if the patient should have a unilateral perception hearing loss. This is a check of the patient's third, fourth, fifth, sixth, seventh and ninth cranial nerves on *both sides*. Other tests that can be done are Romberg, Nose Pointing and observance of the patient's walk. These three responses are interesting but very seldom of diagnostic importance.

If the history of the patient would seem to indicate that the dizziness only occurs when the patient's head is in a certain position or suddenly turned to a certain position, it would be well to try to produce an objective nystagmus by testing

TABLE 2. DIAGNOSTIC TABLE

History & Findings	True Meniere's	Hemorrhage	Ischemia	Blood Sludging	Infectious Labyrinthitis	Pontine Angle Tumor
Age Group	25 - 50	40 - 70	40 - 70	30 - 50	Any Age	Any Age
Chronic Otorrhea	No	No	No	No	Yes	No
Sudden Onset	Nearly Always	Nearly Always	Seldom	Seldom	Sometimes	Seldom
Prodromal Symptoms	Nearly Always	No	Seldom	Usually	Sometimes	Always
Periods of Remission	Nearly Always	Never	Maybe	Usually	Never	Never
Slow Onset	Very Seldom	Never	Yes	Yes	Usually	Always
Vertigo	In Attacks	Usually	Seldom	Seldom	Usually	Seldom
Normal Hearing	Never	Never	Maybe	Maybe	Never	Never
Slight Hearing Loss	Early Cases	Never	Usually	Usually	Never	Never
Moderate Hearing Loss	Usually	Maybe	Maybe	Maybe	Maybe	Maybe
Marked Hearing Loss	Extreme Cases	Usually	Never	Never	Maybe	Maybe
Fistula Test	Negative	Negative	Negative	Negative	Positive	Negative
Normal Labrynth	Sometimes	Never	Maybe	Maybe	Not Done	Usually
Hypofunction	Sometimes	Usually	Never	Maybe	Not Done	Maybe
Hperfunction	Very Seldom	Never	Maybe	Maybe	Not Done	Maybe
Both Ears Involved	Very Rarely	Never	Maybe	Seldom	Never	Never

the patient with certain sudden movements of the head. These are known as positional or postural nystagmus tests and are very well described by Lindsay and Cawthorne. The cause of these symptoms and findings is not known and their diagnostic significance has not been evaluated as yet.

With this information at hand, we can now try to make a diagnosis. I have made a table which has been very useful in arriving at a diagnosis. (See table 2) It is well appreciated that this table is not infallible and is subject to exceptions. Nevertheless, by following it one's average of correct diagnoses on these cases will be quite good. Any attempt to go into the possible exceptions would be very time consuming.

TRUE MENIERE'S

At this point, it would be well to speak about the term, *Meniere's disease*. This is a distinct entity, the pathology of which has been well established. Therefore, the use of such terms as *Pseudo-Meniere's* or *Meniere-Like* is confusing and misleading and their use should be avoided. True Meniere's disease is a chronic increased endolymphatic pressure characterized by periods of remission and exacerbation. It is for this reason that it is sometimes referred to as a "hydrops of the labyrinth."

In figure 1 there is a section of a left cochlea



Fig. 1. Cochlea section showing increased endolymphatic pressure.

which shows this pathology very well. In the first basilar turn, lower right hand corner, I have drawn a dotted line to represent normal Reisner's membrane. The letter "R" is where it actually is in this specimen. You will see that the scala media, marked "SM," is very much dilated. This is also called the cochlear duct. It contains endolymph and is directly continuous with the inside of the membranous labyrinth of the semicircular canals. The scala vestibuli, marked "SV," is much reduced in size and as it gets near the apex this space is obliterated. The scala tympani, marked "ST," is normal in size near the base but as we get near the apex the distension of the scala media has herniated the basilar membrane down into and reduced the size of the scala tympani as marked by the two "b's."

Several of my medical colleagues have admonished me to not forget that Eustachian tube dysfunction and/or allergy is the underlying cause of nearly all of these dizzy cases. Right or wrong, here is how I rationalize my thinking along these lines. Tubal dysfunction and/or allergy can and does cause a very great number of middle ear problems. The symptoms of this condition is one of hearing loss. In the many hundreds of such cases that have been proven, I cannot recall a single case in which dizziness has been a complaint. If middle ear disease alone can produce dizziness why would not at least a fair percentage of these proven cases have had dizziness? Therefore, I consider dizziness a disease of the inner ear or brain but not of the middle ear. Now there is no question in my mind that allergy may affect the inner ear. I shall speak further about this in discussing treatment.

There is one other condition that may cause dizziness and even severe vertigo. That is a variable amount of collected cerumen in the ear canal and especially if this is impinged against the ear drum. It is not very frequent. I have seen about 15 cases in 25 years. When it does occur it is usually very definite. I think that the explanation

is a neurological reflex stimulation from the ear canal back through Arnold's nerve to the inner ear.

TREATMENT

Now as to treatment. You will recall at the start, I said that an optimistic approach to this problem with assurance to the patient of a favorable prognosis is the most effective weapon that we can use. I want to repeat and emphasize this point. The treatment of true Meniere's disease is very hard to evaluate because of the marked tendency of this condition to develop spontaneous remissions. The so-called Furstenberg diet was in vogue 20 years ago and then dropped in popularity practically to oblivion. Within the past two years, it is gaining again and personally I am prone to try it now. It consists of a low salt intake and restricted fluid intake with 45 grains of ammonium chloride three times daily for three days and then off for three days and so on. Lately, I have been alternating this regime on every second patient; the intervening patients are being tried on 250 mg. of diamox® twice daily. This is a new drug that has been fairly effective in the treatment of glaucoma.

If the frequency and severity of attacks becomes so great that the patient is unable to work for about half the time and the hearing in the affected ear, (this condition practically never involves both ears) remains below the 40 per cent mark, then destruction of the labyrinth by any one of several surgical methods is indicated. This is a relatively simple procedure as compared to the older intracranial eighth nerve section of Dandy. In properly selected cases, destruction of the labyrinth can be considered a permanent and satisfactory cure of the condition. It is obvious that only a small percentage of cases of Meniere's disease ever become severe enough to have this done. I have never found the use of nicotinic acid to be very effective in Meniere's disease.

If there is an associated nasal allergy or dermatological allergy, an anti-allergen approach to the problem is indicated. Any one of several of the better known antihistamines can and should be tried. An elimination diet on basis of the history could well be tried. In my humble opinion, the prolonged desensitization of a patient with a positive skin test is unwarranted. This is particularly true when the only allergen is our old acquaintance, "house dust."

In cases of ischemia or blood sludging, the use of nicotinamide in from doses of 25 to 100 mg. twice daily is very often effective. This is particularly true in cases of blood sludging. If the periods of ischemia are due to low blood pressure any one of the hypertensive agents is indicated. If none of these attacks seem to produce results an anti-allergy approach as previously mentioned is then indicated. If the diagnosis has been fairly certain that a hemorrhage is the causative factor, no treatment is of any value. However, ascorbic acid in large doses is indicated for its possible blood

vessel repairative factor. In all cases the dizziness and vertigo disappear in from within two to four months but the hearing *never* returns. It is of interest to note that in the writer's series, 12 of these hemorrhage cases have occurred during the act of sexual intercourse.

In cases of infectious labyrinthitis and pontine angle tumor, surgery is the treatment of choice—complete radical mastoidectomy in the case of infectious labyrinthitis and craniotomy removal of the tumor in the case of a tumor. In those great number of dizzy cases which cannot be properly put into one of the foregoing diagnostic classifications, the treatment is psychotherapy and expectant. It is my hope that my presentation has not further confused an already confusing problem.

The Story Behind the Word

Some Interesting Origins of Medical Terms

Pest—From the Latin word "pestis" meaning a deadly disease, this in turn may be derived from the term "perdo" meaning "to ruin." The term has now come to mean anything destructive or very mischievous.

Perleche—A superficial inflammatory disease of the lips and the angles of the mouth. It was formerly believed to be an infection but is now considered a symptom of riboflavin deficiency. This condition was described in 1885 by the French physician Lemaistre. The name perleche is a French term and literally means "by, or through, licking," because it was believed that the licking of the lips caused the disease. The term is composed of "per" meaning "by, through, or the," plus "lecher"—to lick.

Parotid Gland—The ancient Greeks used the term "parotida" coming from the Greek words "para," or beside, and "ous," or ear, to designate this gland and it also was used for a tumor or swelling under the ear. The term later fell into disuse and in the seventeenth century it was revived by Riolan, a French anatomist.

Paratyphoid—In 1896 Achard and Bensaude reported a case of "typhoid fever" in which they found an organism which was not *B Typhosis* and to which they gave the name of "paratyphoid." They coined this term from the Greek "para," or beside, plus typhoid.

Palm—This word is derived from the Latin word "palma" meaning the palm or flat of the hand. Related is the Anglo-Saxon word "folm" meaning the flat of the hand. All of these words probably stem from the Sanskrit word "phal" meaning to open, and thus meaning the open hand or the flat of the hand. The palm tree was supposedly so named because its broad flat leaves resemble the palm or the flat of the hand.

—HARRY WAIN, M. D., Mansfield, Ohio.

New Mood-Changing Drugs

CHAUNCEY D. LEAKE, PH. D.

MANY new kinds of behavior-altering drugs are being introduced with great success, not only for tranquilizing manic excitement and anxiety, but also for counteracting depression, and for promoting more satisfactory mental stability. Physicians have long been acquainted with the use of such behavior-altering drugs as alcohol, the many differing types of hypnotics, and of various kinds of analgesics.

Long clinical experience has shown the sedative value of bromides, paraldehyde, and the barbitals. Morphine analgesics in the relief of traumatic pain, and salicylates and aminopyrines in easing congestive pain, usually calm mental anguish. Clinicians are thoroughly familiar with the central nervous system stimulating effects of amphetamine, caffeine, and related drugs. There has also been long experience with many differing types of addictive drugs, such as cocaine, and the opium derivatives. It seems likely that any of the mood-altering drugs may become addictive in susceptible patients.

The dramatic success of such new drugs as chlorpromazine (thorazine®), reserpine (serpasil®), meprobamate (miltown®, equinal®), pipradrol (meratran®), azocyclonol (frenquel®), and methyl-phenidylacetate (ritalin®), has aroused great interest in the possibility of sufficient alteration of mood and behavior by chemicals to give promise of vast betterment in the care of mental illness. It is important that the scientific facts regarding these new chemicals be carefully and frequently evaluated, so that physicians may be able wisely to apply such knowledge to the effective care of their patients.

GENERAL CONSIDERATIONS

Physicians alert to psychosomatic relationships realize that mood and behavior are greatly modified by the physical condition of patients, and by their environment. Self-realization and insight are usually more readily secured in patients who have problems of an interpersonal nature, if their nutritional and physiological status are satisfactory. As patients get older, their nutritional status requires more careful attention, especially in relation to vitamin and protein intake. For optimum nervous stability certain vitamins seem to be necessary, such as thiamine, pantothenic acid, ascorbic acid, and nicotinamide. In the psychoses large doses of vitamins often are found to be clinically helpful. These agents also seem

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to be important in preventing degenerative changes in the nervous system.

Of growing importance is the role of 5-hydroxytryptamine ("serotonin"). Dr. Irving Page and his associates of the Cleveland Clinic have made extensive studies of this compound in relation to peripheral action in altering the blood pressure, and also to some of its kidney effects. Gaddum, Brodie, and others are indicating the importance of 5-hydroxytryptamine in nerve conduction and nervous system functioning.

It may be suggested that optimum nerve function is dependent upon maintaining an optimum ratio of intracellular to extracellular 5-hydroxytryptamine. When there is a relative increase in intracellular 5-hydroxytryptamine there seems to be increased tension, alertness, irritability, and a tendency toward convulsive behavior. On the other hand a relative excess of 5-hydroxytryptamine extracellularly seems to be associated in the central nervous system with depression and withdrawal.

5-hydroxytryptamine is chemically related to epinephrine and norepinephrine. It is an indole, and is rapidly excreted in the urine, when it appears extracellularly, as indole-acetic acid. Its importance in brain function is indicated by the observation of Brodie and his associates, that reserpine acts as a tranquilizing agent by releasing 5-hydroxytryptamine from cells in the central nervous system, especially in the brain stem. Erspamer, a pioneer in studying 5-hydroxytryptamine has well reviewed the many reports on the compound, as part of a comprehensive survey of indole-alkylamines.

Chemical considerations associated with 5-hydroxytryptamine and its chemical relatives, suggest the importance of the "blood brain barrier" in connection with the peripheral administration of some of these drugs. No specific structure, the "blood brain barrier" is a functional block to certain chemicals that seem to be easily dehydrogenated by brain cells, as an adaptive protection to the organism as a whole. This bar-

From the Pharmacology Laboratory of the Ohio State University Health Center, Columbus. Presented before the staff of the Veterans Administration Hospital, Chillicothe, Ohio, February 15, 1956.

rier may be overwhelmed by overdosage. The physiological action of these chemicals suggests also the importance of feed-back to the central nervous system from the periphery, particularly of proprioceptive impulses from muscles and joints. Such feed-back contributes to mental alertness and tension, as does hyperthyroidism.

Whatever may be the factual significance of chemical and physiological factors in mental disturbance, physicians will be wise in their counselling and example to follow the Hippocratic injunction to try to get the "externals" to cooperate, whether these "externals" be physical surroundings, nutrition, family, or friends. Certainly however the several new tranquilizing drugs will aid physicians in obtaining more satisfactory response in mentally disturbed patients. Some act primarily as stimulants in depressed or schizoid conditions, while others are tranquilizers in excited or manic states.

RAUWOLFIA

The roots, leaves, and juice of Rauwolfia were used from primitive times by the Hindus for relief of fevers, insomnia, dysentery, seizures, and frenzy. An apocynaceous plant, it was named *Rauwolfia serpentina* in honor of a pioneering sixteenth century botanist and physician. What may have been a related plant called "serpentina" was described by Dioskorides, the surgeon of Nero, as useful in quieting frenzy. Modern studies were made by Sen and Bose beginning in 1931, who noted clinically that the powdered root lowers blood pressure and quiets mania.

An alkaloid, reserpine, was isolated in 1952 by Schlittler, which was found by Bein to have hypotensive and sedative action. The first clinical report on reserpine was made by Wilkins in 1953. Many independent clinical reports made at a symposium arranged by the New York Academy of Sciences in 1954, agreed on the value of reserpine as a hypotensive tranquilizing agent for helpful use in psychiatry, geriatrics, hypertension, and in gynecology. The powdered whole root is also available as a tranquilizing agent for office practice and for producing a gradual sustained lowering of blood pressure in hypertension. It is claimed that the powdered whole root, satisfactorily standardized, gives activity not due to reserpine alone.

Reserpine is a white crystalline compound, soluble in alcohol and glycols, insoluble in water, and sensitive to light in solution. It is a complex chemical compound containing an indole nucleus, with many methoxy groups. Reserpine and the other alkaloids of Rauwolfia are readily absorbed from the alimentary tract, and are distributed through the body. Their fate in the body is not known. Brodie and his associates indicate that reserpine acts by liberating 5-hydroxytryptamine from blood platelets, intestinal mucosa, and the brain.

The powdered whole root of Rauwolfia is administered orally in dosages of 50 to 100 mg., usually in tablets. Reserpine is available in tablets containing 0.25 mg. each. The daily dose of reserpine varies from 0.1 to 1 mg. given usually orally at bedtime. Clinical effects develop slowly but are significant and marked. Blood pressure is reduced in hypertension, a mild slowing of the heart occurs, which assists in maintaining adequate circulation, and marked tranquilization is observed. Tension, emotional instability, and over aggressiveness are relieved, without causing drowsiness or sleepiness. No untoward effects are noted on the liver, kidney, or blood cells. On the other hand there may be nasal congestion, and disturbance in appetite. In some emotionally sensitive patients, reserpine has been found to cause depression. This may be serious enough to involve suicidal tendencies. No tolerance or addictive properties have been noted.

Clinically Rauwolfia has been found to reduce complaints of dizziness, insomnia, excitability, irritability, and anxiety. It may tend to promote a sense of well-being among nervous individuals, and it reduces premenstrual tension and nymphomania. Outstanding has been the effectiveness of Rauwolfia in anxiety and in hypertension associated with excitability. In all of these respects it is particularly useful in old people. It may be helpful in obsessive-compulsive drives, and generally promotes tranquillity. There may be some constipating effect from it. It may be used safely with other drugs such as veratrum. However, its use should be carefully controlled clinically and its administration should be stopped promptly if depression or other untoward effect occurs.

CHLORPROMAZINE HYDROCHLORIDE (Thorazine®)

In extending the sedative action of antihistaminics, the Rhone-Poulenc laboratories in France developed chlorpromazine, 3-dimethyl-amino-propyl -2-chlor-phenothiazine hydrochloride. This is a white crystalline powder soluble in water with a pH of 5, and stable for a short period. It is quickly absorbed from the alimentary tract and distributed through the body. While its fate in the body is not known, it appears to be relatively rapidly destroyed or eliminated, so that dosage has to be repeated every four to six hours in order to be effective.

The pharmacology of chlorpromazine has been well studied. It has low toxicity on single administration, and on repeated administration at 10 mgm. per kilogram orally, there is depression, decrease in liver weight, and increase in adrenal weight. On the other hand no effects are noted on the blood. Chlorpromazine abolishes response to a conditioned stimulus, antagonizes motion sickness and drug-induced emesis, and depresses motor activity. Chlorpromazine is mildly antihistaminic and relaxes smooth muscles. It potentiates the effects of hypnotics, analgesics, and

anesthetic agents. It lowers temperature slightly, and has a mild adrenalytic effect. While it has no anticonvulsive action, it tends to reduce the hypertensive action of "serotonin." Tolerance seems to develop to chlorpromazine on repeated administration. Direct experiments show that chlorpromazine antagonizes 5-hydroxytryptamine. It also increases brain-stem content of adenosine triphosphate.

French investigators first noted the central depressant effects of chlorpromazine, and its inhibition of psychic disturbance. It was used to help in producing low-temperature artificial hibernation for surgery. Kent and his associates found chlorpromazine useful as an antiemetic. Lehman and Hanrahan reported fully on the inhibiting effect of chlorpromazine in psychomotor excitement and manic conditions.

Extensive clinical evidence now clearly shows the value of chlorpromazine in controlling nausea and vomiting due to a variety of causes including drugs, radiation, pregnancy, and motion sickness. In severe cases, effective control is quickly obtained by an intramuscular dose of 25 mg. thrice daily, with subsequent change to an oral dose of 10 mg. twice daily. For milder cases or in children with viral gastritis 10 mg. orally every four to six hours may be satisfactory. If the drug cannot be tolerated by children, it may be given in a dose of 25 milligrams by rectal suppository every four to five hours.

Chlorpromazine is useful in controlling psychomotor agitation. It has a general sedative effect. On the other hand it may relieve hallucinations and delusions in schizophrenia. In depressive states benefit from the drug is usually observed only on stopping administration. For improvement in psychotic patients high doses seem necessary, averaging around 300 mg. daily. This dosage should be reduced as soon as any evidence of improvement is seen. In agitated senile patients, 25 mg. thrice daily by mouth may be helpful.

Chlorpromazine again seems helpful in relieving symptoms of parkinsonism, and it sometimes helps in controlling withdrawal symptoms in opiate or alcohol addictions. It has been used as an adjunct to various analgesics in relieving pain in cancer. As an adjunct to anesthesia, or in pre-anesthetic medication, chlorpromazine may be useful. Preoperatively, it relieves anxiety, aids in control of restlessness in spinal anesthesia, and may reduce postoperative nausea and delirium.

Chlorpromazine interestingly is very helpful in relieving persistent hiccup. Here an intravenous dose of 25 mg. is used, and repeated intramuscularly if needed in four to six hours.

While favorable response to chlorpromazine is considerable, there are unfortunately a number of undesirable side effects. Usually 80 to 90 per cent of patients respond favorably to chlorpromazine. However, in 40 per cent of patients drowsiness may be expected. There may also be fall in blood

pressure, and care should be used to avoid untoward vascular effect in cardiac disease.

The most unsatisfactory aspect of chlorpromazine therapy is the possible occurrence of allergy. This may even occur by contact sensitization among nurses or physicians. Fortunately the allergic reactions clear promptly on stopping treatment or contact. In some patients urticarial rashes may appear, while others may show gastroenteric distress. Jaundice is the most serious untoward effect from chlorpromazine. Fortunately the incidence seems to be less than 1 per cent. The jaundice seems to be due to allergic swelling around biliary ducts, without injury to liver function. A mild fever may occur following a week or so of chlorpromazine treatment with jaundice developing subsequently. These conditions generally clear on withdrawing the drug.

On the appearance of any untoward symptom the administration of chlorpromazine should be stopped. Usually after a week or so the drug may again be used without any further untoward effect or allergic reaction. Chlorpromazine should not be used in the presence of liver disease, and it is not wise to give it when a patient is under the influence of hypnotics or alcohol.

MEPROBAMATE

In studying a series of propane derivatives, Berger found marked sedative and muscle relaxing effects from 2-methyl-2-N-propyl-1, 3-propanediol dicarbamate. In this drug, called meprobamate, one finds actions similar to those of mephensin, but with longer duration. It antagonizes convulsions due to strychnine or metrazol®. Its action has been localized on multineural reflexes. It does not seem to modify mono-synaptic reflexes.

Meprobamate was introduced under the trade name "miltown" and is also known by the trademark "equinal." Clinical reports by Selling, and by Borrus, show that meprobamate has marked sedative action with no toxicity. The drug is ordinarily given in tablets containing 400 mg. each, four times daily. When sedative effects are observed, the dosage may be reduced, and if improvement continues the drug often may be fully withdrawn.

Meprobamate is useful as a sedative in anxiety and in manic states. It is helpful as an adjunct to direct psychotherapy. It aids in clearing behavior problems due to anxiety, to hysteria, and it is helpful in the withdrawal symptoms of alcoholism. Meprobamate is not useful in the psychoses.

Meprobamate appears to be a practical, safe, and clinically useful central nervous system depressant, which has very low toxicity, and which is not habit forming. It promotes restful sleep and general muscle relaxation, without depression or hang-over. It aids in clearing anxiety, tension headache, and neurogenic skin conditions or abdominal distress. It generally aids in reducing

tension, irritability, and restlessness, and may aid in the control of tension states leading to epilepsy.

PIPRADROL AND AZOCYCLONOL (Meratran® and Frenquel®)

Highly interesting action on the central nervous system has been found by Brown and Werner among the piperidyl-benzhydrols. These agents illustrate neatly the importance of relatively slight changes in chemical constitution in regard to significant differences in biological activity.

The drug pipradrol, called "meratran," is a-(2-piperidyl) benzhydrol hydrochloride. It is a bitter crystalline compound, readily absorbed from the alimentary tract, but with unknown fate in the body. It seems to be destroyed or excreted within four to six hours. With little local action, its effects are chiefly on the central nervous system. Himwich and his associates show that this drug stimulates the central reticular substance of the brain, and that this is followed by cortical stimulation. Pipradrol does not increase blood pressure and it has no effect on the gastroenteric system or on respiration.

Since pipradrol is a general central nervous system stimulant, it has been used therapeutically to counteract mild depressive states. It apparently has no significant action on the autonomic nervous system, and its use is not followed by wakefulness. Strikingly it seems to be especially effective in controlling motor tic syndromes. Patients suffering from torticollis are often aided by treatment with pipradrol, and it may also help in relieving lumbar muscle spasm in low back pain. Its clinical value in these conditions is indicated by reports by Fabing. He finds no untoward side effects, and no toxicity has been reported. The drug is administered orally in tablets of 1 mg. each three to six times daily.

In studying the action of related compounds, it was observed by Fabing, that the gamma-isomer has startlingly different effects. Azocyclonol is a-(4-piperidyl) benzhydrol hydrochloride. Here the nitrogen in the piperidine ring has been moved over two positions from that which it occupies in pipradrol. The resulting compound, azocyclonol, is a white bitter crystalline substance partially soluble in water and rapidly absorbed from the alimentary tract. It apparently is excreted or destroyed in four to six hours. This compound is not stimulating to the central nervous system at all, but rather is a depressant. It is in fact an antagonist of pipradrol, as well as of other central stimulating agents such as amphetamine or cocaine. Azocyclonol potentiates the depressant action of hypnotic and analgesic drugs. It is itself a relaxing agent and has insignificant toxicity on single administration or on repeated dose.

Clinical trials by Fabing and Hawkins indicate that azocyclonol is useful in acute schizophrenic conditions. It has an antagonistic action in model psychoses produced by lysergic acid diethylamide,

or by mescaline. The name "frenquel" was given in respect to the ability of the compound to quell frenzy.

Azocyclonol may be useful in acute schizophrenia in a dosage of 10 mg. once or twice daily, by mouth. It is not helpful in chronic schizophrenia or in hallucinating seniles or alcoholics. Azocyclonol has little or no effect in psychotic or depressive states, nor on obsessive-compulsion disorders. It does not aid in handling anxiety conditions.

Both pipradrol and azocyclonol require much more extensive study under controlled clinical conditions in order to indicate clearly their clinical usefulness, and also to find out whether or not there may be any significant untoward reactions. So far results with them have been promising. It is remarkable that in these two compounds, such slight differing chemical composition may produce on the one hand a central nervous system stimulant, pipradrol, and on the other hand a central nervous system depressant, azocyclonol.

METHYL-PHENIDYLACETATE (Ritalin®)

Meier has recently developed another interesting behavior-altering drug, methyl-phenyl-2-piperidine-acetate HCl, called "ritalin" (methyl-phenidylacetate [Ciba]). A white crystalline compound soluble in water with a pH of 3 in 10 per cent aqueous solution, it is quickly absorbed from the alimentary tract, and seems to be rapidly destroyed in, or eliminated from, the body.

Methyl-phenidylacetate is a central stimulant. In doses of 1 mgm. per kg. in experimental animals, it causes an increase in spontaneous activity, with maximum restlessness in about an hour, and with gradual recovery without untoward effect in about two hours. Against short acting barbiturates, it has an analeptic effect. There is little action on smooth muscle, on cardiovascular function, or on blood. No toxic effects have been observed.

Recently Ferguson reported on its use in 127 chronic schizophrenic patients of long standing and with a wide age distribution. These patients were markedly deteriorated, with strong negativistic response. On administration of 10 to 30 mg. of methyl-phenidylacetate, thrice daily by mouth, for a period of several weeks, 101 showed significant clinical improvement. No untoward effects were noted, and there was no interference with sleep. In some cases improvement was dramatic after several days' administration, while in other cases improvement occurred more slowly. There was observed to be a gradual improvement in awareness, a greater degree of responsiveness, with gradual ability of the patient to assume self-care and in many instances to show favorable enough response to warrant discharge from the hospital.

Methyl-phenidylacetate appears to be a slow-

acting central stimulant of extreme importance in long standing chronic schizophrenia. Its use here may really be of tremendous value, if the drug can be satisfactorily appraised and utilized. It gives hope that other chemicals may be found that may be as helpful clinically.

SUMMARY

Several new drugs have recently been developed which give real promise of selective action on the central nervous system in such a way as to help physicians significantly in the management of mental disorder. Some of these new drugs, such as pipradrol (meratran®), and methyl-phenidylacetate (ritalin®), are stimulants, and may be used in selected depressed states. Others seem to be tranquilizing agents, such as chlorpromazine, reserpine, meprobamate, and azocyclonol (frenquel®), which may be selectively employed in various types of excitement, over-anxiety, or mania.

Gradually the clinical indications for the use of these different drugs will be developed on the basis of experience. Meanwhile physicians will be wise to watch for surveys on the use of these drugs, so that they may be employed with reasonable chance for success. There appears to be considerable variation in their character of effectiveness, so that they should be used with discrimination.

Pipradrol seems to be useful in relatively mild depressed states, and in some conditions involving muscular tics. Methyl-phenidylacetate on the other hand seems to be useful as a general stimulating drug in severe deteriorated chronic schizophrenia of long standing.

Chlorpromazine is useful in managing nausea, vomiting, psychomotor excitement, and as an adjunct to analgesia and anesthesia. Rauwolfia and reserpine seem to be useful as general tranquilizing agents in hyper-excitability, over-anxiety, restlessness, irritability, and mild manic conditions. Meprobamate appears to be useful as a general sedative, which promotes restful sleep and general muscular relaxation without depression or hang-over. It seems to be indicated in irritability, restlessness, tension, and in withdrawal symptoms of alcoholism. Azocyclonol is a neuromuscular relaxing agent, and appears to be indicated as a general depressant and as an adjunct to analgesic drugs. It appears to be indicated in psychomotor excitement, and might be helpful in the excitement stages of acute schizophrenia.

While the toxicity of these new drugs is relatively slight, one may expect allergic reactions of various sorts from the use of chlorpromazine, and it is likely that with extended experience some tendency toward addiction may be noted from the new depressant drugs.

The successful introduction of new drugs altering mood and behavior gives promise of extended development of an understanding of the etiology

and control of various mental illnesses. It appears likely that the metabolism of naturally occurring indoles, such as 5-hydroxytryptamine, is important in the functioning of the central nervous system, and thus in maintaining emotional and mental stability.

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Allergies as Causes of Middle Ear Effusion

ROBERT E. BOSWELL, M. D.

THE otolaryngologist is showing increasing interest in allergic manifestations in and around the ear. Some of the more common sites of involvement are the auricle, external canal, tympanum, middle ear, Eustachian tube, and cochlea.¹

The physiology of middle ear effusion has been succinctly reviewed by Suehs.² The mucosa of the middle ear is subject to abrupt changes under even slight stimulation. Fluid originates in the blood serum, sometimes as the result of negative pressure alone and sometimes due to the added influence of inflammation and increased capillary permeability. This fluid may be increased or replaced by the mucous secreted by acinous glands in the Eustachian tube and by goblet cells in both the tube and the tympanic cavity. However, the primary factor is an obstructed Eustachian tube, and it is probable that allergic phenomena account for about 15 per cent of such obstruction.

Ashley³ suggests that typical allergic reactions may be initiated not only by protein sensitivities but also by emotional upsets and by physical agents as well. But he maintains that whether the initiating factor be house dust, shell fish, sunlight, or emotional stress, the stimuli follow the same pathways and produce the same result: the climax of otologic allergy is transudate formation, with resultant tissue anoxia. The primary reaction begins in the peripheral vascular bed, whenever the parasympathetic nerves gain dominance over the sympathetic system and thus permit dilatation of the small vessels. This, together with the increased permeability of the capillary walls, permits the loss of serum and electrolytes into the surrounding tissues, causing edema. It is the edema which produces the allergic manifestations.

Williams⁴ advances the theory that the principal functional lesion in allergy appears to be a vasospasm affecting the arteriole. The use of vasodilators, such as histamine and nicotinic acid, is intended to release such spasm. He asserts that even though an antigen-antibody reaction may be associated with the vascular reaction, and may in itself contribute to the cell damage, yet this is merely a secondary phenomenon.

The presence of eosinophils has caused much controversy. Hansel¹ feels that they are the most dependable diagnostic sign of allergy, but there is evidence that eosinophils may be produced at will, simply by causing a localized tissue anoxia.⁵

During the past few years the phrase "physical allergy" has entered the literature with in-

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creasing frequency. This term refers to all those allergic manifestations which are produced by light, heat, cold, mechanical irritation, changing weather, or even air travel. Present evidence indicates that a typical vascular reaction is the inevitable autonomic response to environmental stress of any type.

In our modern fast-paced world we see people of all strata breaking under the incessant strain of life's increasing demands. Such continuous emotional stress tends to raise the sensitivity level of our psychosomatic mechanism. Thus we find that patients laboring under unusual fear or anxiety suddenly become allergic to various stimuli to which they would normally remain unresponsive. Therefore it seems reasonable to conclude that a knowledge of the mechanism of psychosomatic allergies opens the door to a better understanding of otolaryngology.

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Intermediate Coronary Syndrome

The intermediate coronary syndrome presents a clinical picture of acute coronary artery disease midway between that of angina on the one hand and acute myocardial infarction on the other. Its genesis is prolonged acute coronary insufficiency. It results in moderate myocardial injury, which may be reversible.

Pain is usually present, and is distinguishable from angina in that the precipitating factor is not obvious, the duration is longer, and it is not abolished by rest and nitroglycerin. In addition to the pain, there are other evidences of myocardial damage, such as evolutionary changes in the ST segments and T waves, which are usually reversible. QRS changes occur.—Sidney Davidson, M.D., and Robert E. Raborn, M.D., Lake Worth: *J. Florida M. A.*, 42:640, February, 1956.

Presented before the Section on Otorhinolaryngology at the Annual Meeting of the Ohio State Medical Association, Cincinnati, April 19-22, 1955.

Care and Treatment of Recent Fractures of the Nose

J. GORDON HIMMEL, M. D.

FRACTURED noses are said to be more common than any other fractures except those of the clavicle and the wrist. They are, certainly, the most inadequately treated fractures and for this reason, the author has written this paper.

The failures in treatment are due to:

1. "Leave it alone" attitude, because the pain soon disappears and the bleeding is usually minimal.

2. The edema of the tissues which may mask the deformity and the attitude of "Let's wait till the swelling goes down."

3. Dependency on x-ray diagnosis alone, which may de-emphasize the degree of fracture or displacement.

4. The failure to teach medical students and house officers adequate treatment; and the teaching of certain surgical textbooks, to fill the nose with vaseline gauze and hope for the best.

Fractures and displacements of the nasal bones are best replaced as soon as practicable after the injury. There should never be a wait until the swelling has subsided. However, this does not mean that the attending physician has to rush to the emergency room or to a home in the middle of the night to set the fracture. A wait of a few days up to about eight days is possible without any loss of mobility of the parts.

X-ray pictures are usually not of much help, except when they may show allied fractures of the maxillary bones or the zygoma. They are of value if the case has a medicolegal or Industrial Commission aspect.

Nasal injuries are best evaluated by clinical examination. The history of the shape of the nose preceding the accident or a previous picture may be of help in evaluating the findings.

TYPES OF FRACTURES

There are two types, generally, of nasal fractures:

1. The "squashed in" type resulting from a frontal blow, in which the nasal bones are displaced inwards and downwards, the nasal bones spread down on the maxillae and the dorsum and profile are flattened.

2. The lateral fracture may consist of one bone fractured inwards, due to a sideward blow; and the other bone may be fractured outward, with the nasal septum involved; so that the whole nasal mass is pushed to one side.

The nasal bones and cartilages are covered on the outside with a thin subcutaneous layer and skin; and on the inside with a thin submucous layer and mucosa. Any blow on the nose which causes intranasal bleeding means that the bones

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or cartilage have been broken and that they have cut the mucosa. This does not mean that every blow causes marked displacement.

Any bleeding may be checked by packing the nose with adrenalin® on gauze placed in the nose. A subcutaneous hematoma may be expressed by external pressure on the whole nose with a gauze pad. The nasal bones and cartilages are then palpated lightly for any displacements or irregularities. If in doubt, as to any displacement, procede as with setting a fracture.

Then the nose is either sprayed internally with 2 per cent pontocaine® or cotton packs dipped in 2 per cent pontocaine® or 5 to 10 per cent cocaine are placed in the nose. With a head mirror and a good light, any displacements of the nasal septum, tears in the septal mucosa, or hematomas under it, indicate a septal fracture. For a slight fracture this is enough anesthesia. If the fracture is more severe, block anesthesia with 1 per cent procaine and adrenalin® (with or without hyaluronidase) is used, the procedure being as with a rhinoplasty anesthesia.

Various elevators can be used. However, a large curved hemostat with cotton wool around it, serves well. The patient, preferably, lies flat on a table. The elevator is then introduced through the vestibule and up under the bones. The bony fragments are elevated up and with external pressure with the fingers of the other hand, molded into the mid-line and in place.

If the fragments are not comminuted, this usually is sufficient. There are no strong external muscles tending to pull the fragments away, after they lock. However, if they are comminuted, a plain gauze dressing may be packed intranasally high under the nasal bones and kept there for several days. A plain adhesive tape dressing externally or a small metal splint will suffice. A heavy plaster or rubber compound for a dressing is not required.

The frontal or "squashed" fracture may have their nasal bones pushed laterally onto the cheeks. These are elevated similarly and held in place the same way. However, they may have a tendency to sink in. This can be held in place by using the wire sling as advocated by Brown. He uses two pieces of No. 24 stainless steel wire on a large curved needle. The needle and the steel suture are passed through the lateral frac-

Submitted May 21, 1954.

ture lines on the sides of the nose and through the cartilaginous septum and thence through the lateral fracture line on the opposite side. Two sutures are thus placed, and are tied around flat lead plates on the sides of the nose. This acts as a sling holding the bones in place. This sling is kept on for 10 to 14 days and then removed. Other physicians and supply houses have advocated splints with prongs going into the nose, under the nasal bones and attaching to a plaster of Paris headpiece. These fantastic splints are not needed.

Intranasal inspection may show the cartilaginous septum to be pushed out of its groove on the floor of the nose. Placing a finger on the displaced side of the septum, it can be pushed back into the groove. Do not be misled by trying to set in place a septum which was deviated before any recent trauma.

Childhood fractures are handled the same way, except that a mild general anesthetic may be required. These fractures are easily missed and with the parts of the nose out of place, the deformity increases as the nose grows.

Following birth, the nasal septum may be pushed out of its groove, or the anterior nasal spine may be broken. They usually straighten out in a few days; however, if inspection several days after birth shows displacement immediate steps may save surgery later on.

RULES TO REMEMBER

1. Any nasal bleeding, after a blow on the nose, means a fracture. Every nasal fracture does not mean displacement.
2. Do not wait for swelling to subside.
3. Do not depend on x-ray diagnosis only.
4. Do not wait too long to set a nasal fracture—not over eight days.
5. If in doubt about a fracture, anesthetize and attempt to elevate the fragments. If broken, they will move; if not broken, they will not move and no harm has been done.
6. Any serious effort to replace bones in their normal position and hold them there is better than forgetting about the nasal injury and allowing it to heal as it will.

Dietary Restriction of Sodium

Dietary limitation usually results in an approximately equal decrease in sodium and chloride intake, thus is not productive of any electrolyte imbalance. With the greater availability of low sodium foods, the task of dietary restriction of sodium is becoming simpler. Since bread and butter provide such a major portion of the usual intake of sodium (one slice of regular bread—200 mg. of sodium; one 10 gram pat of butter—100 mg.), substitution of salt-free bread and butter is frequently the only major alteration that need be made in the patient's diet habits.—B. L. Martz, M. D., Indianapolis: *J. Indiana State M. A.*, 49:151, 1956.

Franklin County Pelvic Cancer Delay Committee Report

By JOHN H. HOLZAEFFEL, M. D.
Columbus, Ohio, Chairman

The Franklin County Pelvic Cancer Delay Committee met January 18, 1956, at the Columbus Health Center. Three cases were presented.

Case 12: The patient, a 51 year old white female, in May, 1954, was seen by a general practitioner who referred her to another physician. Her complaints were of intermittent bleeding and low abdominal pain, the pain having increased in severity in the last six weeks. Past history reveals her periods had been irregular for past five years. In 1947 the patient had a laparotomy and uterine suspension. Bleeding occurred again in 1950 at which time she again reported to a physician. A biopsy of the cervix was done and reported as negative. Another episode of bleeding occurred in 1952 and she was treated with shots. She then reported to another physician on May 17, 1954, and was referred to the hospital. She was admitted and the pathology report after biopsy was, poorly differentiated squamous cell carcinoma of the cervix, Clinical Stage III. She was treated with cobalt in two applications followed with a course of x-ray therapy.

Comment: *Dr. Francis Gallagher:* There is a four year loss of time here which can be blamed on both patient delay and physician delay.

Case 13: The patient, a 58 year old female, in January, 1954, noticed vaginal bleeding. Menopause was at age 43. She had no trouble following menopause until January, 1954. Through a friend she was referred to physician. She reported to him June 14, 1954, at which time a biopsy was done revealing epithelioma, Grade III. She was sent to the hospital where she received radium treatments to tolerance. Examination five months later revealed a mass on the posterior vaginal wall. Patient's only complaint was of pain. In December, 1954, two months later, she was feeling better, but with no change in the status of her disease. In February, 1955, she developed a rectovaginal fistula. She then saw another physician who advised no further treatment. In March, 1955, the patient became bedfast with complaints of severe low abdominal pain, back pain, constipation and vomiting.

Case 14: This 54 year old female was referred by an internist to another physician on September 14, 1955. Her complaints were of weakness, low abdominal pain, gas, and distension for several weeks' duration. Her periods had been regular until May, 1954, with only two periods since then, the last one being in May, 1955. On examination the cervix was normal. Extending from the cervix, anteriorly and posteriorly, was a hard mass that filled the entire pelvis. Surgery was advised. However, the patient returned to the internist who was not in accord with the physician's decision and treatment was postponed.

The patient returned five weeks later. During the interval the tumor had increased in size. Hospitalization was again advised and carried out. She was admitted on October 21, 1955, with a large ovarian mass. The ovaries were removed, with some difficulty, and biopsy revealed cystadenocarcinoma of the ovary. She then received deep x-ray therapy. Three and a half weeks after discharge she was re-admitted with complaints of low abdominal pain and episodes of nausea and vomiting. On December 12 a colostomy was advised and done in the descending colon.

The Impacted Anterior Shoulder

NICHOLAS MISISCHIA, M. D.

THE writer is acutely aware of the incidence of fractured clavicles and humeri; and face, neck, upper and lower arm paralyses that are occurring in the hospitals with which he is connected, simply because the anterior shoulder of the baby "got stuck." The idea of fracturing clavicles manually to release an impacted shoulder is a thing of the past and is to be condemned as bad obstetrics at the present time.

This report is being written to introduce to the general practitioner (who, it appears, performs most of the deliveries in the general population) a comparatively simple method of freeing the locked anterior shoulder. This paper is not intended to sight statistics on the incidence and causes of shoulder impaction. We are nearly all in agreement that basically this condition is encountered most often in cases of over-sized infants with average maternal pelvises, or normal-sized infants with contracted maternal pelvises. A practitioner who delivers the baby's head and cannot free the shoulder is in a bad predicament, since he will have a dead baby by the time a consultant arrives. Therefore, although the practitioner may not be qualified to practice major obstetrics, he must, in this case, deliver the baby himself if he is to get a live baby.

The method to be described is not a new one, and was taught to the writer in 1940 by one of the obstetrical consultants at St. Ann's Hospital. This procedure had been used numerous times with very gratifying results. Barnum,¹ in 1945, describes a method of freeing an impacted shoulder, which is almost similar to the one to be described. Hunt² describes a procedure (Wood's maneuver or DeLee's tight ring procedure) which depends on "spiraling the impacted anterior shoulder into the hollow of the sacrum or rotating the posterior shoulder anteriorly." The writer has not found this method to be as easy to perform as the one to be described below.

PROCEDURE FOR FREEING IMPACTED SHOULDER

The principle behind this procedure is based on the fact that with the patient supine a horizontal plane through the tip of the coccyx, and perpendicular to the long axis of the mother is further caudad than a similar plane through the upper border of the symphysis pubis. Therefore, the baby's shoulders must be unwound, similar to the unwinding of a bolt from a nut.

Given a case with the head delivered and the anterior shoulder impacted: The operator's hand is inserted posteriorly, beneath the baby, into the uterus. The operator's fingers, in the cubital area of the baby's elbow, gently pushes the elbow

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to the side of the uterus in which the baby's back is lying. This causes a certain degree of flexion of the baby's forearm at the elbow. With the operator's fingers still in the cubital area, it is usually possible for the operator to grasp the forearm, then the hand, and so deliver it to the outside.

Up to this point, the operator follows the same procedure as that described by Barnum.¹ The freed posterior extremity is then wound around the baby's neck. The operator grasps the hand of the baby and gently rotates it over a half circle, while at the same time the operator's other hand rotates the head over a similar arc. This frees the impacted upper shoulder, which now lies posteriorly.

For example, if the baby is lying with its back to the left side of the mother:

The posterior extremity would be the left. This freed extremity is now wound around the baby's neck so that it will lie beneath the chin with the hand above the right side of the face. The operator's right hand grasps the hand of the baby and gently rotates it in a clockwise direction; at the same time, the left hand of the operator rotates the baby's head in a similar direction through a half-circle. The impacted shoulder is now posterior. Delivery usually follows easily from then on, but if not, the whole procedure may be repeated again with the right hand of the baby, which is now lying posteriorly.

TYPICAL CASE PRESENTATIONS

In the last 140 obstetrical deliveries in his private practice the writer found it necessary to employ the above procedure in 7 cases. The incidence in this small series is 5 per cent, indicating that the condition occurs often enough and that the accoucheur should familiarize himself with the procedure.

Case 1. This patient, gravida III, Para II, was at 40 weeks gestation. The previous babies weighed 7½ pounds and 8 pounds 10 ounces, and the deliveries were uneventful. The mother's measurements were average. After a 5½ hour labor the head crowned in a left occiput anterior position. Under cyclopropane anesthesia, and

Submitted July 14, 1955.

aseptic technique, forceps were applied and the head delivered with little difficulty over a central episiotomy.

The anterior shoulder was impacted and could not be freed by the usual method of downward traction of the head, with the assistant exerting pressure on the fundus. Therefore, the posterior arm of the baby was delivered to the outside, wound around the baby's neck, and by gentle spiral traction on the hand through 180°, the anterior shoulder was freed and brought to a posterior position. Delivery was then completed. The baby weighed 10 pounds 8 ounces and is living and well. There were no lacerations to the mother's cervix or vagina and her postpartum course was uneventful.

Case 2. This was a consultation case in which the writer was first called to see the patient when she was in the delivery room, under general anesthesia, and an attempt had been made by the attending physician to rotate an occiput posterior LOP (left occiput posterior) without success. The patient was a young primipara and had been in labor 49 hours. The fetal heart beat had been absent during the previous 18 hours. The membranes were ruptured and meconium was pouring out of the vagina.

An attempt to rotate the head manually was unsuccessful, for it was well impacted in the vagina. Forceps were then applied to the head, and by employing Bill's³ modification of the Scanzoni maneuver the head was rotated with moderate difficulty. After reapplying the forceps, the head delivered rather easily over a right medio-lateral episiotomy. The shoulders became impacted in an A-P position, and, although manually rotated into the right oblique plane, could not be freed. The posterior arm was therefore delivered to the outside, placed about the baby's neck, and gentle rotation through 180°, in a clockwise direction, freed the anterior shoulder. Delivery was then completed rather easily.

The baby was macerated and weighed 7 pounds 9 ounces. The cervix and vagina were examined and found to be intact, except for the episiotomy. Examination revealed also a tunnel-shaped birth canal with a generally contracted pelvis. This patient, with her next pregnancy, should have the benefit of x-ray pelvimetry at 37 weeks of gestation, and most likely a cesarean section.

Case 3. The patient, gravida III, Para II, at 40 weeks of gestation had been delivered of her first two babies in another city. The birth weights were 8½ and 10 pounds respectively. Her history revealed that the second delivery was difficult and the baby developed a paralysis of the arm. Recovery was complete after 4½ months.

The mother was a small girl, 5 feet tall, and, her weight increase was from 102 to 120½ pounds during her pregnancy. Her external measurements were: intercrural 26 cm., interspinous 22 cm., external conjugate 18 cm.; the true conjugate 11 cm.

She ruptured her membranes spontaneously and went into strong labor 6 hours later. After 4 hrs. 30 min. of rapid labor the head was found to have come to a standstill in low-mid pelvis, position left occiput transverse, with the anterior cervical lip impinged, and a thin rim of cervix still palpable around the sides of the pelvis. During the course of several contractions the lip was slowly and gently pushed over the baby's head, and dilatation thus was completed. Forty-five minutes later the head crowned slightly, still in left occiput transverse position. Under ether anesthesia, delivery was completed by forceps

rotation to a left occiput anterior, and low forceps over a central episiotomy.

The anterior shoulder became impacted; by bringing out the posterior arm and, after winding it around the baby's neck, using it in corkscrew fashion, the anterior shoulder was freed, and delivery completed. The baby weighed 10 pounds 7 ounces and showed no signs of injury. The cervix was examined after delivery of the placenta, and was found to be intact. There was no abnormal blood loss.

Case 4. This patient, gravida IV, Para III, at 40 weeks of gestation had three children, weighing 9 pounds 12 ounces, 10 pounds 3 ounces, and 9 pounds 6 ounces, respectively at birth.

Labor was rapid and short (2 hours) and the head crowned in a right occiput anterior position. Under general anesthesia, forceps were applied and the head delivered with moderate traction over a central episiotomy. The anterior shoulder (left) was impacted, so the posterior arm (right) was delivered to the outside, wound around the baby's neck, and counter-clockwise rotation through 180° freed the anterior shoulder. Delivery was then completed rather easily. There were no cervical or perineal lacerations and the mother had an uneventful postpartum course. The baby weighed 11 pounds 4 ounces and showed no evidence of injury.

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The Clinical Evaluation of Common Hepatic Disorders

The last two decades have witnessed far-reaching changes in the diagnosis of liver ailments. Physicians today have a number of special tests which are at their disposal as well as a large accumulation of experience and knowledge gained through observation of liver malfunction.

Despite recent advances, present-day tests for liver disease do not cover all conditions, especially minor ones. Some tests give only rough indications, others show up a disorder only after it is irreversible. Test results may be clouded by such non-hepatic disturbances as severe respiratory ailments. Nevertheless, research in this field does hold the promise of improved diagnostic tests in the future.

What makes the liver especially significant at the present time is the increase in liver disease since World War II. In part this is due to viruses brought back by soldiers returning from foreign service. Blood transfusions in recent years have also been responsible for some liver ailments.—*Summary* of paper read by Dr. Franklin M. Hanger, Professor of Medicine, College of Physicians and Surgeons, Columbia University, at the 64th annual meeting of the Association of Life Insurance Medical Directors of America, October 20, 1955, New York City.

Presumed Amniotic Fluid Embolism With Recovery

JACK A. PRITCHARD, M. D., and ROBERT J. DUGAN, M. D.

WOMEN who die from amniotic fluid embolism classically have ruptured membranes, tumultuous labor, and either expire suddenly during labor with abrupt circulatory collapse, or die following delivery from uterine hemorrhage and shock.^{8,9} Histologic examination of the lungs reveals particulate material from the amniotic fluid in the pulmonary vessels.

In those cases where death following delivery is associated with massive uterine hemorrhage, significant alterations in the hemostatic mechanisms have been described, including varying degrees of hypofibrinogenemia, thrombocytopenia, and hypoprothrombinemia.^{5,6} Amniotic fluid is known to be thromboplastic.¹⁰ The alterations in hemostasis noted in patients with amniotic fluid embolism are compatible with the concept that the defects are due to the thromboplastic effect of the infused amniotic fluid on maternal blood.

Histologic evidence of amniotic fluid debris in the lungs would not be obtainable in a case of amniotic fluid embolism which did not prove fatal. However, the paucity of known conditions in which a parturient woman can develop acute hypofibrinogenemia would appear to make it not unreasonable to consider amniotic fluid embolism as the probable diagnosis in those women who have demonstrated (1) ruptured membranes, (2) tumultuous labor, (3) immediate postpartum hemorrhage due neither to lacerations of the genital tract nor retained products of conception, and (4) acute hypofibrinogenemia in the absence of abruptio placentae, prolonged intra-uterine retention of a dead fetus, or evidence of a blood transfusion reaction.¹

This report concerns two cases from the obstetric service of the University Hospitals of Cleveland which fulfill these four criteria. All laboratory methods employed have been described previously.^{4,5}

CASE REPORTS

Case I. The patient, para 2-2-0-0-2, was admitted on June 9, 1954, not in labor but with recently ruptured membranes. Prior to this her prenatal course had been normal. Blood drawn and fortuitously stored at the time of this admission subsequently was observed to have formed a large clot which entrapped virtually all the red blood cells. The patient was discharged to await the onset of labor.

Twenty-nine hours after the rupture of the membranes labor started. Twenty-five minutes after the first contraction and immediately after her arrival on the delivery floor, a sluggish infant weighing 2280 grams was delivered spon-

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taneously without episiotomy or perineal laceration. Two minutes later the placenta was expressed; it showed no evidence of premature separation. This was followed by somewhat excessive vaginal bleeding associated with an atonic uterus which, in spite of therapy with oxytocics, remained firmly contracted only when constant fundal massage was employed.

Twenty-five minutes after delivery the patient was slightly cyanotic, her blood pressure was 90/40 mm. Hg. and her pulse rate was 140. Venous blood drawn at this time for use in cross-matching appeared not to clot but later a very small clot could be seen floating in the serum with practically all of the red cells settled to the bottom of the tube. Intravenous aqueous fluids and oxygen by mask were begun at the time of the venipuncture and 20 minutes later the first of four units of blood was started. The blood pressure at this time was 70/30; the uterus remained somewhat atonic and blood loss from the vagina continued to be excessive. Manual exploration of the vagina and uterus did not reveal any lacerations or retained placental fragments. No clots were observed in the blood coming from the vagina.

Two hours and 25 minutes after delivery, in spite of the administration of 1000 ml. of blood, the blood pressure ranged from 74/40 to 64/0. Venous blood was drawn into a silicone-coated syringe through a coated needle. About one ml. of this blood was placed in a tube which contained 0.1 ml. (2 drops) of thrombin (1000 National Institutes of Health units per ml.) for a clot observation test. One ml. of blood was placed in each of three 13 by 100 mm. Pyrex test tubes and incubated at 25°C. to determine the clotting time. The remainder was mixed with dried ammonium and potassium oxalates and the plasma was separated for the quantitative measurement of its fibrinogen. The clot observation test within a few seconds showed the formation of a clot which rapidly retracted to form a very small nubbin which entrapped virtually none of the red blood cells. The clotting time in plain glass tubes was 28 minutes which is normal for the method

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Submitted April 4, 1955.

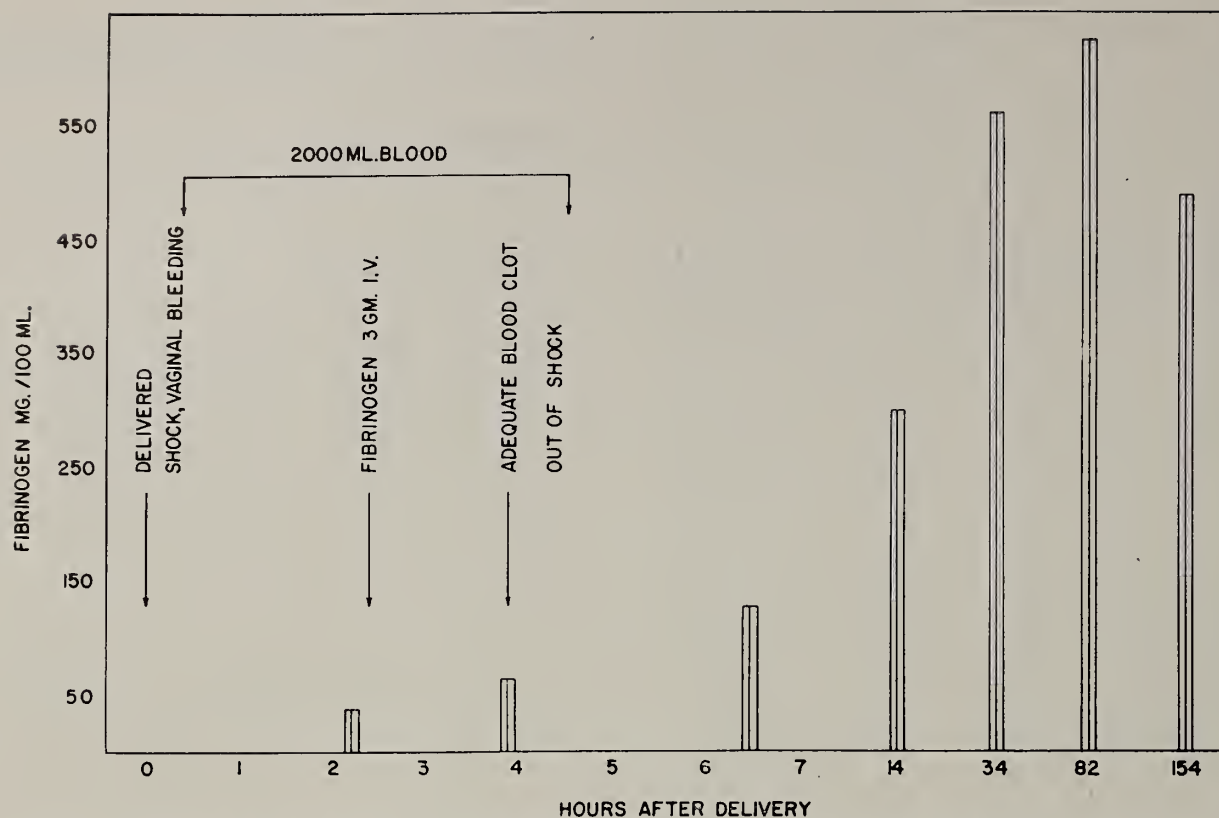


Fig. 1. Shown are the levels of circulating fibrinogen in Case I following delivery. Three Gm. of fibrinogen and 2000 ml. of blood were given.

used. Due to the small size of the clot, however, the end point was not sharp. The plasma fibrinogen concentration was 40 mg. per 100 ml. The clot lysis time of this plasma when recalcified and incubated at 37°C. was longer than six hours.

Fifteen minutes later 3 Gm. of human fibrinogen were given intravenously followed by the third unit of blood. The blood pressure when the fibrinogen was given 70/30 and the patient continued to show the cardinal signs of shock. During the next hour the blood loss from the vagina was less, the uterus remained more firm, the systolic blood pressure ranged from 80 to 90 and the diastolic pressure from 50 to 60, and the pulse rate dropped from 140 to 100. At this time the clot observation test yielded a clot appreciably larger than when first done, but a clot which was still abnormally small. The clotting time was 24 minutes, the plasma fibrinogen concentration was 67 mg. per 100 ml., and the clot lysis time of recalcified plasma incubated at 37°C. was 5 hours.

Since the condition of the patient appeared to be significantly improved, it was decided to withhold further therapy with fibrinogen and, instead, to give another unit of blood. The patient continued to be more alert, the uterus remained firm without constant fundal massage, and vaginal bleeding decreased to normal. Six hours after delivery and one hour after the fourth unit of blood, the patient was definitely out of shock and was transferred to the postpartum floor. At this time the plasma fibrinogen concentration was 124 mg. per 100 ml., the platelet count was 151,000 per cu. mm., and the hematocrit was 38. The fibrinogen concentration continued to rise; 14 hours after delivery it was 295 mg. per 100 ml. The serial studies of the concentrations of fibrinogen are shown in figure 1.

The subsequent hospital postpartum course was uneventful except for endometritis, the signs and symptoms of which disappeared promptly following antibiotic therapy. The mother and infant were discharged from the hospital on the sixth postpartum day.

Case II. The patient, para 4-3-0-1-3, noted transient painless vaginal bleeding two weeks before delivery. Three days before the onset of labor the membranes ruptured spontaneously. On October 30, 1954, she was admitted in desultory labor; at this time there was no vaginal bleeding, the blood pressure was 136/84 mm. Hg., and the pulse rate was 78. The frequency and duration of contractions increased until they were almost continuous. Spontaneous delivery of a 2940 gram apparently normal infant without episiotomy or laceration of the perineum occurred less than five hours after the first contraction was noted by the patient. The placenta was expressed one minute later. It showed no evidence of premature separation.

During the next 20 minutes blood loss from the vagina was somewhat excessive and the uterus tended to be atonic in spite of parenteral administration of oxytocics. Blood drawn at this time in a plain glass tube clotted but when next observed one hour later the clot was very small and most of the red cells were free from the clot. The small size of the clot did not appear to be due to intense fibrinolytic activity since incubation of the tube overnight at 37°C. did not result in dissolution of this clot. Another specimen of venous blood was obtained 45 minutes later; this blood was never observed to clot.

Fundal massage kept the uterus fairly well contracted but vaginal bleeding continued; an intravenous infusion of dilute pitocin® was started. Manual examination of the vagina and uterus revealed no lacerations.

Two hours after delivery the blood pressure had fallen to 70/35 and the pulse ranged from 120 to 150 in spite of the intravenous administration of aqueous fluids. During the next 30 minutes 1000 ml. of whole blood was given after which the blood pressure was 90/50 and the pulse rate was 130. Ecchymoses in the skin at the site of fundal massage and bleeding from the nose were noted. Venous blood was drawn two and one-half hours after delivery to estimate the concentration of circulating fibrinogen; the blood

was drawn from an antecubital vein while blood was being given intravenously in both arms. The clot observation test revealed a clot large enough to entrap most of the red cells; the fibrinogen concentration in the plasma of this blood was 158 mg. per 100 ml. The clot lysis time of recalcified plasma incubated at 37°C. was longer than two hours and less than 12 hours.

Three grams of human fibrinogen were then given intravenously followed by 1000 ml. more of whole blood. Within the next hour the vaginal bleeding ceased to be abnormally excessive, the uterus remained well contracted, and the patient was out of shock. At the end of this period, three and one-half hours after delivery, the plasma fibrinogen concentration was 224 mg. per 100 ml. and the platelet count was 136,000 per cu. mm.

The following day the fibrinogen level was 327 mg. per 100 ml.; at this time the hematocrit was 28. The subsequent postpartum course was uneventful and the mother and infant were discharged from the hospital on the seventh postpartum day.

DISCUSSION

In both cases there was early rupture of membranes, tumultuous labor, and delivery followed by shock, excessive vaginal bleeding, and evidences of inadequate clot formation. In Case I it was possible by quantitative measurement, as well as by observing the size of the blood clot relative to the amount of serum and extruded red cells, to demonstrate an alarming degree of hypofibrinogenemia. In Case II the very small size of the clot in blood drawn 20 minutes after delivery indicated probable severe hypofibrinogenemia. Analysis of plasma obtained two hours later, at a time when whole blood was running into veins of both arms, but before fibrinogen therapy, revealed an abnormally low, but not dangerously low, fibrinogen level of 158 mg. per 100 ml. The average concentration of fibrinogen in the plasma of 18 normal parturient women was found in these laboratories to be 451 mg. per 100 ml. with a standard deviation of ± 71 mg. per 100 ml.⁴

The degree of hypofibrinogenemia in Case I was quite similar to that found in a nonfatal case of presumed amniotic fluid embolism by Reid, Weiner, and Roby.⁷ There is a striking parallelism in the laboratory data between Case II and one reported by Chessin and Greenwald.²

When considered from the standpoint of patient survival or of subsequent postpartum difficulties, the therapeutic regime employed in these two patients proved adequate. However, in retrospect, the dose of fibrinogen given to the first patient probably was not optimal. At the time of administration of the 3 Gm. of fibrinogen or following this when the second clot observation test indicated that the blood clot was still abnormally small, perhaps more fibrinogen should have been given. A total dose of 6 Gm., undoubtedly, would have better corrected the marked deficit in the concentration of circulating fibrinogen.

In Case II, in spite of transfusion with 2000

ml. of blood, the hematocrit the day following delivery was 28. Perhaps it would have been wise to have given the fibrinogen as soon as inadequate clot formation was demonstrated following delivery. Conceivably with the earlier use of fibrinogen, blood loss would have been less and the degree and the duration of shock could have been modified.

Diagnosis and management of the hemorrhagic state in these patients was greatly facilitated by the clot observation test. With this procedure the amount of clottable fibrinogen in the blood can be estimated within a few minutes after adding the patient's blood to a solution of thrombin. This test, first advocated for this purpose by Page,³ is described in detail elsewhere.⁵

SUMMARY

Reported are two cases of presumed amniotic fluid embolism with recovery. The bases for the diagnosis of amniotic fluid embolism were the presence of (1) ruptured membranes, (2) tumultuous labor, (3) immediate postpartum hemorrhage and shock not due to lacerations of the genital tract or retention of products of conception, and (4) acute hypofibrinogenemia without abruptio placentae, prolonged intra-uterine retention of a dead fetus, or evidence of a blood transfusion reaction.

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Diverticula of the Colon

A series of 47,000 consecutive barium enemas showed 4,000 people of all ages to have diverticula; 600 had evidence of diverticulitis, of whom 144 required an operation. In one sense this would suggest that 144 of 4,000 people having diverticula (3.6 per cent) will require operation. This figure, while still high, is probably a fair indication of the relative infrequency of patients requiring operation for diverticula of the colon. —Philip W. Brown, M.D., Rochester, Minn.: North Carolina M. J., 17:51, 1956.

Some Respiratory Problems of the Newborn

A Pediatric Review

EDWARD C. MATTHEWS, M.D.

MIST THERAPY FOR PREMATURES

HIGH humidity environment for premature infants in their first days of life has become, in many centers, a routine therapeutic measure. For prematures manifesting evidence of an obstructive respiratory disorder, the addition of nebulized water mist to the high humidity environment is widely practiced. Silverman and Anderson³ point out that no systematic evaluation of the effects of water mist had been published, and for that reason they undertook a controlled study of the effects of the administration of nebulized water mist to 200 prematures during the first 72 hours of life.

Of the 200 infants studied, 103 were in the water-mist group and 97 acted as controls. All infants in the study were placed in Isolettes® under comparable environmental conditions with the exception that, in the water-mist group, sterile distilled water was nebulized into the Isolette® with a Vapojet® delivering approximately 50 ml. of water per hour. No water mist was used in the control group. For both groups the humidity was maintained at 90 to 100 per cent, the oxygen concentration at 32 to 46 per cent, and the bed temperature at 30.0 to 31.1°C. Conditions of the trial were terminated when the infants had reached 72 hours of age.

The trial and control groups were analyzed and found to be comparable with respect to sex, color, birthplace, economic level of parents, birthweight, mother's age, birth rank, route of delivery, and position at the time of birth. The groups were also comparable in regard to age at the time of admission to the nursery and in regard to antibiotic therapy administered. Respiratory function in the two groups at various periods during the trial was evaluated on the basis of respiratory rate and retractions—the latter being scored from 0 to 10 depending on the severity of the retractions.

In both groups about 55 per cent of the subjects exhibited retractions sometime during the study period, and the "retraction scores" were comparable for the two groups. When the two groups were compared in regard to age of death in those who died both before and after 72 hours of life, there was no significant difference. The two groups were also comparable in regard to the frequency of pathologic findings in the lungs and in regard to the incidence of major infections and major anomalies. It was therefore the con-

The Author

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clusion of the authors that nebulized water mist had no practical benefit in the treatment of obstructive respiratory disease in prematures in the first 72 hours of life.

The fact that water mist does not seem to have therapeutic value in premature infants adds significance to a recent report by Hoffman and Finberg² who noted an increase in serious infections due to *Pseudomonas aeruginosa* in prematures coincident with the increased use of mist atmosphere in the therapy of these patients. They point out that growth of *Pseudomonas aeruginosa* is enhanced by a high humidity environment, and it is their contention that the supplying of a favorable atmosphere for this organism by the use of high humidity environments is responsible for the increased incidence of this organism as a serious pathogenic agent in hospital nurseries.

They report 13 cases of infection caused by *Pseudomonas aeruginosa* over a period of about one year. Infection was manifested in the form of conjunctivitis, omphalitis, and pustular skin lesions, which in one patient went on to noma involving the nose and cheek. Blood cultures were positive in three of the 11 patients in whom cultures were obtained. Five of the patients died, and, in each case, death was considered to have resulted from the infection.

If high humidity and mist therapy are to be used in the management of premature infants, it is important that infections in these patients be recognized early and that appropriate cultures be taken to determine the causative organism. Polymixin B is the drug of choice in the treatment of *Pseudomonas aeruginosa* infections, the organism being resistant to other antibiotics commonly given both therapeutically and prophylactically to premature infants. The authors therefore stress the importance of the early recognition and therapy of these infections.

HYALINE MEMBRANE DISEASE

The treatment of patients with hyaline membrane disease continues to be unsatisfactory. In order to establish a successful and rational ther-

Submitted January 18, 1956.

apy or prevention of this disease, there has been much investigation of the etiology and pathogenesis of hyaline membranes. Three general theories as to the origin of hyaline membranes have been developed, each of which is supported by some investigative work.

The membranes may have their origin from inspissation of aspirated amniotic fluid, they may have their origin in material derived from the infant, or they may result from an interaction of elements derived from the infant and from aspirated material. Gitlin and Craig¹ have carried out experimental studies which indicate that the membranes are composed largely of material derived from the infant and that aspirated amniotic fluid, if it does play a part in the pathogenesis, acts only to enhance the formation of the membrane.

Lungs of 5 infants who died with pulmonary hyaline membrane were studied. The presence of large amounts of fibrin in the membranes was revealed by staining the tissues with fluorescein-labelled antiserum against human fibrin. Similar staining techniques applied to smears of amniotic fluid revealed only small quantities of fibrin insufficient in amount to account for the large quantity in the membranes in the lungs. Quantitative immunochemical methods failed to reveal the presence of fibrinogen in the amniotic fluid.

The evidence compiled in this investigation indicated that hyaline membranes were composed principally of fibrin which quantitatively exceeded the amount available from amniotic fluid. Since fibrin cannot pass through capillary walls, the authors concluded that the fibrin in the membranes must have had its origin from fibrinogen which, for reasons as yet unexplained, migrated across the capillary wall into the alveoli, there to be converted into fibrin. Since amniotic fluid contains thromboplastic material, it is possible that aspirated amniotic fluid may enhance the conversion of soluble fibrinogen into insoluble fibrin, thus accelerating or augmenting the production of the actual hyaline membrane.

It is clear that these studies, while throwing light on the morphologic nature of hyaline membranes, raise a fundamental question relative to the pathogenesis of the membranes. Pulmonary effusion must occur to account for the fibrinogen in the alveoli. The pathogenesis of the pulmonary effusion remains to be clarified.

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KEEPING UP WITH MEDICINE

- THOSE WHO give preconception and antepartum care to the children-bearing women of our day have a great responsibility not only to protect the immediate and future health of the woman but also to protect the child from metabolic imbalances and deficiencies, the residual effects of which may constitute systemic and teratologic scars which would plague his future health and even that of his offspring.

* * *

- THE FIRST clinical manifestation of allergy in the newborn is urticaria. It manifests itself by transient rashes usually with only small wheals. It is rarely noted on the chart except by the nurse alerted to it on the lookout for impetigo. It is usually gone in a few days.

* * *

- THE INCIDENCE of "colic" in the babies of allergic families is about twice that of nonallergic families. When both parents have allergic diseases, in one series 73 per cent of the babies suffered from colic.

* * *

- THE MOST COMMON complication of atopic dermatitis is impetigo. It is usually caused by a staphylococcus or a streptococcus and in the more stubborn cases, the germ is of the hemolytic variety.

* * *

- ON THE OTHER hand *Seborrheic* dermatitis is the most frequent dermatitis in infancy.

* * *

- THE HIGH PERCENTAGE of infants with seborrheic dermatitis who develop allergic diseases indicates either that these infants have a greater tendency to develop such disorders or that it is impossible to differentiate at this age the disease from atopic dermatitis.

* * *

- DYSPNEA AND WHEEZING alone are not enough upon which to make a diagnosis of bronchial asthma.

* * *

- IT IS A MATTER of common observation that the dose of pollen extract necessary for infants and children has no relation to age or weight, but rather depends upon the degree of sensitivity.

* * *

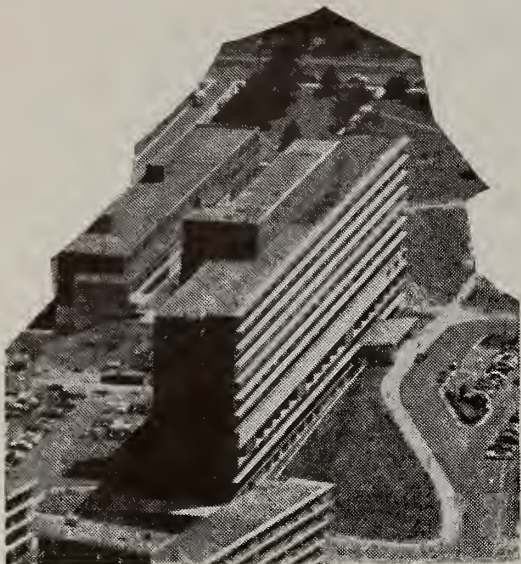
- THE ADMINISTRATION of a new drug to an allergic child is always an experiment and calls for extreme caution.

* * *

- TOXIC REACTION to vaccines are proportional in frequency and severity to the concentration of the vaccine injected.

* * *

- IT SEEMS ILLOGICAL to dump large quantities of sewage into streams from which supplies of drinking water must be obtained by costly methods of filtration and treatment.—J. F.



A Case Record

From The University Hospital,
Columbus, Ohio

Edited Under the Auspices of the Ohio Society of Pathologists

Philip Wasserman, M. D., President

Presented by Philip B. Hardyman, M. D., and Emmerich von Haam, M. D. Edited by Dr. von Haam

PRESENTATION OF CASE

THIS 68 year old retired policeman was admitted to the medical service of The Ohio State University Hospital complaining of recent appetite loss and epigastric distress. He had been in good health until approximately two months prior to admission, when he developed progressive anorexia and abdominal distress described as a feeling of soreness and fullness rather than severe pain. It was aggravated by ingestion of food and cold beverages.

About 10 days prior to admission he developed nausea and vomited about a half hour after meals. The vomitus consisted of undigested food and brought relief of his symptoms. At other times he received some alleviation of his abdominal distress by sitting upright with a cushion behind his back. There was no distress during the nights or mornings, and drinking of milk was of no benefit. At the onset of the nausea and vomiting he noted a tarry stool. His brief illness was associated with a weight loss of 10 pounds.

Ten years previously he had postprandial epigastric distress associated with hunger pains. An x-ray examination at that time is supposed to have revealed a prepyloric ulcer. He was placed on a medical regimen consisting of diet and antispasmodics and received complete relief of his symptoms.

Inquiry into his past medical history revealed that he had a fracture of his pelvis at the age of 48, a cholecystectomy and appendectomy at the age of 54, and a subtotal thyroidectomy for a colloid goiter seven years before his final admission. For the past two years he had had exertional dyspnea and had been told that his

electrocardiogram revealed some heart disease. There were no other cardiac symptoms.

PHYSICAL EXAMINATION

Inspection revealed a well developed, well nourished white male in no distress. The blood pressure was 130/100, pulse 80 and irregular, respirations 24 and temperature 98.6°F. Examination of the head and neck revealed no abnormalities other than a thyroidectomy scar. The chest was increased in anteroposterior diameter; the lungs were clear. The heart tones were distant and the rhythm was irregular; no murmurs were heard. There was an old abdominal right rectus surgical scar. The abdomen was soft with an area of midepigastric tenderness. A suggestion of a midepigastric mass was noted by one observer. The liver was one fingerbreadth below the right costal margin. Rectal examination revealed a 2 plus enlargement of his prostate.

LABORATORY DATA

The white blood cell count on admission was 10,000 with a normal differential and rose to 43,200 prior to death; the red blood cell count and hemoglobin were 5.6 million and 15.2 Gm. respectively and remained within normal limits throughout his hospitalization. The urine had a specific gravity of 1.022, was negative for sugar and protein and showed no red or white cells in the sediment. The serology was negative for lues.

Determination of the total proteins, A:G ratio, prothrombin time, serum amylase, sodium, potassium and chloride levels and the CO₂ combining power all gave normal values. The blood urea nitrogen was 21 mg. and rose to 84.5 mg. on the day prior to death. A fasting gastric analysis showed 225 cc. of brown, guaiac-positive liquid which showed no free hydrochloric acid and 55 units of total acid. The stool was guaiac-positive.

Submitted January 20, 1956.

His electrocardiogram showed an old posterior myocardial infarction and auricular fibrillation, with the rate of the heart beat varying from 42 to 90.

ROENTGENOGRAPHIC EXAMINATION

Review of his plate taken during the patient's first gastrointestinal disease 10 years ago showed no distinct ulcer but a prepyloric or antral gastritis. The present x-ray studies of his chest revealed bilateral chronic bronchitis and severe emphysema. He also had an old right apical lung lesion with partial calcification of his pleura. The diaphragm was flaccid on both sides. The stomach was constricted, the distal two-thirds of the wall appeared thickened and indurated with no particular large mass protruding into the lumen.

Three days before his death he developed a consolidation in both lower lobes.

HOSPITAL COURSE

The patient was transferred to the surgical service and a Billroth I procedure was done with removal of a large portion of the stomach. The patient received 500 cc. of blood during the operation and tolerated the procedure well. On the evening of the day following the operation he suddenly became unconscious and cyanotic when he was gotten out of bed. He revived rapidly and complained of pain under his left rib margin which then shifted to the abdomen. This was associated with a transient rise in pulse and respirations and a rise in temperature to 101°F. The following day the temperature, pulse and respirations again rose and remained elevated for the remainder of life.

His subsequent postoperative course was downhill. No bowel sounds were heard, his abdomen remained distended, and he vomited bile-stained fluid. He developed rales in both bases and required frequent suctioning of his trachea. He was digitalized, was treated with streptomycin, penicillin and sodium iodide and was maintained on parenteral fluids. His urinary output progressively dropped with an associated rise in the blood urea nitrogen. He died quietly on the eighth postoperative day.

CLINICAL DISCUSSION

DR. P. B. HARDYMON: The patient presents a conglomeration of symptoms which really suggests only one disease, namely, a cancer of the stomach. The duration of his symptoms lasting only two months seems a little short for this type of lesion and normally the patients have vague complaints from the stomach for 6 to 7 months before they submit to surgery. However, you note from the history that he had had gastric difficulties 10 years ago which were diagnosed as a prepyloric ulcer. His present symptoms are those of overdistention of the gastric wall, and they differ quite markedly from the hunger pains of an ulcer.

Patients suffering from pyloric obstruction always have distress soon after eating and as a rule they do not get much relief from milk or alkali. So our patient gave a fairly typical story of gastric obstruction. His vomitus 10 days prior to admission consisted of undigested food and brought him relief of his pains, again suggesting strongly that distention of the gastric wall was the cause for his discomfort.

There was another interesting observation which we have noted before in patients who are obstructed. They will often tell you that they feel better when they sit up. It is the same as with patients who have esophageal hiatal hernia. Apparently when the patients lie down the full and distended stomach exerts an increased pressure upon the diaphragm and aggravates the distress. The history of a tarry stool should indicate to you that the patient was bleeding from his stomach or duodenum with the production of acid hematin by free hydrochloric acid.

PREPYLORIC ULCER (?) TEN YEARS AGO

This brief illness was associated with a 10 pound weight loss, which is important although it is found in both benign and malignant lesions of the stomach. Typical cases of carcinoma of the stomach commonly show a 15 to 25 pound weight loss. Ten years ago he had symptoms of postprandial epigastric distress and hunger pains. A gastrointestinal series at that time supposedly revealed a prepyloric ulcer. This is interesting because of statistics in regard to the location of lesions in the gastric mucosa and the occurrence of carcinoma.

Fifty-two to 68 per cent of all cancers of the stomach develop in the prepyloric region. For this reason we maintain that an uncomplicated duodenal ulcer is primarily a medical problem, while a prepyloric ulcer should remain a surgical problem. It would be interesting to postulate that his prepyloric lesion discovered 10 years ago developed in the ensuing years into an inoperable carcinoma of the stomach. The fact that he was apparently cured of his symptoms by medical regime does not rule out the possibility that he did have a precancerous lesion. A small residual area may have remained which grew and now is threatening his life.

In addition to his gastric complaints the patient had some exertional dyspnea for the past two years and had been told that an electrocardiogram showed some heart trouble. There were no other cardiac symptoms. The high diastolic pressure indicates to me that this man was probably a hypertensive. His pulse showed an irregular rhythm suggestive of auricular fibrillation.

A midepigastic mass was noted by one observer. That is always a problem. This one observer happened to be a very astute medical student and I don't know whether he was right or wrong. The presence of a palpable mass in

a lesion of the stomach invariably indicates extension of the tumor from the gastric wall to the omentum, and most surgeons will consider this a sign of irresectability and will only consider palliative surgery.

His liver was one fingerbreadth below the right costal margin and no mention was made as to whether it was smooth or nodular. He could have had a large liver with metastasis, or he could have had a congested liver of impending heart failure. Metastatic carcinoma in a large liver would usually give the organ a nodular, firm character with a hard liver margin. On the rectal examination no ledging of the peritoneum or any beading was noted, which means that no pelvic metastases were present.

His admission white count was fairly normal, while the marked leukocytosis the day prior to his death implies probably a peritoneal contamination. The urine showed a pretty good concentration and was apparently normal until after surgery, when red and white blood cells and casts appeared. This would indicate some renal damage, either on an arteriosclerotic basis or produced by the severe surgery followed by what appears to have been a terrific contamination of his peritoneal cavity. The blood urea nitrogen was first normal and rose terminally to 84 mg. That means that he had a slowly mounting retention of nitrogenous products. I checked his fluid output and found it normal. They were keeping him purposely slightly dehydrated. I think he had a preëxisting damaged kidney which did not stand up well under this period of stress.

The gastric analysis showed no free hydrochloric acid, which is classical for carcinoma of the stomach, although it is not always true. A gastrointestinal series revealed a marked constriction of the lower half of the stomach. An electrocardiogram showed a possible old posterior myocardial infarction with an auricular fibrillation. I wonder why this patient was not digitalized prior to surgery and why digitalization was postponed until he got into trouble? I believe I would have insisted upon a more careful evaluation of this patient's cardiac status and have urged preoperative digitalization.

The patient was transferred to the surgical service and a Billroth I procedure was done with removal of a major portion of his stomach. Now there is something we have to consider when we do a Billroth I. To get the duodenum without stress close to the suture line, it has to be mobilized. In order to do so we invariably expose the superior mesenteric artery, which of course can be damaged to the point of traumatic thrombosis.

The patient seemed to tolerate the procedure well. However, on the evening of the day following surgery he suddenly became unconscious and cyanotic. Something happened when he was gotten out of bed. He revived and complained of pain under his left rib margin which then

shifted deep into the abdomen. That to me means peritoneal contamination with the onset of peritonitis.

His subsequent postoperative course was downhill. He had no bowel sounds. The abdomen was distended and he vomited bile-stained fluid. That his vomitus was bile-stained would certainly indicate that his anastomosis was functioning. He developed rales in both bases, which is the ominous sign of pulmonary edema and incipient heart failure. Now he was digitalized and given streptomycin and penicillin—a very effective combination of antibiotics for peritoneal contamination. His urinary output progressively dropped with an associated rise in the blood urea nitrogen. He died quietly on the eighth postoperative day.

Let us now summarize the diagnosis. They told us that part of his stomach was resected. I must assume that he had a carcinoma of the stomach as I can make no other diagnosis. As to his postoperative complications, I may safely state that he died of a peritonitis, paralytic ileus and possibly thrombosis of his superior mesenteric artery. The latter may also have been an embolus originating in a damaged left ventricle. In other words, he could have had a mesenteric thrombosis or embolus, which represents the "sudden" catastrophe which befell him when he was gotten out of bed.

CLINICAL DIAGNOSIS

1. Carcinoma of the stomach.
2. Status post subtotal resection of stomach.
3. Diffuse purulent peritonitis.
4. Thrombosis or embolism of superior mesenteric artery.
5. Arteriosclerotic heart disease.

PATHOLOGIC DIAGNOSIS

1. Muroid adenocarcinoma of stomach.
2. Status post subtotal resection of stomach.
3. Thrombosis of abdominal aorta at the level of the celiac artery.
4. Acute peripancreatic abdominal abscess.
5. Arteriosclerotic heart disease.
6. Acute necrotizing bronchopneumonia.
7. Mild chronic pyelonephritis.

PATHOLOGIC DISCUSSION

DR. EMMERICH VON HAAM: I have enjoyed the clinical discussion very, very much and I have really only little to add. We are presenting this case not because of the difficulties of the preoperative diagnosis, which I agree with Dr. Hardyman seems quite obvious, but because of the postoperative complications. Why should this patient, who had apparently been well prepared medically, die after a gastrectomy by the hands of a master of surgical technic, and could anything have been done to prevent this fatal outcome?

The autopsy showed the following gross findings: The peritoneal cavity as a whole was clean,

there was no diffuse peritonitis; but there was a recent peripancreatic abscess 4 cm. in diameter which already was fairly well walled-off. It was located right over the suture lines and was filled with thick yellow pus. The gastroduodenal end-to-end anastomosis was patent and no gross leakage of the sutures could be discovered. The wall of the small and large bowels showed edema, dark purplish discoloration, mucosal hemorrhages and confluent ulcerations—suggestive of a massive acute arterial infarction of the bowels.

This infarction was apparently caused by a 9 cm. thrombus which was located in the abdominal aorta and extended into the celiac, superior mesenteric and both renal arteries. The abdominal aorta was severely sclerotic and the thrombus was firmly adherent to the sclerotic plaques of the posterior wall. It did not extend above the diaphragm. The heart showed arteriosclerotic heart disease as expected, but not of unusual severity. No large myocardial scars were present. The lungs were atelectatic and showed bilateral confluent bronchopneumonia.

Other gross findings included irregular small granular kidneys, an enlarged and nodular prostate, a freshly infarcted left testicle, and a small arteriosclerotic aneurysm of the right iliac artery. No residual tumor tissue could be found in the abdominal cavity or in the mesenteric lymph nodes.

MICROSCOPIC EXAMINATION

Sections through the heart showed moderate hypertrophy of the muscle fibers with small foci of fibrosis. One branch of the coronaries showed an old occlusion. Section through the thrombus attached to the aorta showed all characteristics of an antemortem blood clot. The lungs represented a picture of a rapidly progressive diffuse pneumonic process. Section through the liver showed the picture of a Zahn infarct with severe parenchymatous and moderate fatty degeneration.

The wall of the small and large intestines showed early arterial infarction with mucosal necrosis. Section through the adrenals showed lipid depletion of the cortex with lymphocytic infiltration of cortex and medulla suggestive of severe adrenal exhaustion. The kidneys gave the histological picture of mild chronic pyelonephritis. Examination of the surgically removed portion of stomach showed a mucoid adenocarcinoma which had metastasized to two regional lymph nodes removed with the mesentery.

To link all these findings together, I might say that all these lesions give testimony to severe postoperative shock and probably can be explained on this basis alone. The embolic nature of the thrombus in the aorta can be definitely ruled out. A traumatic thrombosis caused by the manipulation of the vessels as Dr. Hardymon suggested must still remain a possibility. The massive but early infarction of the small intestine and portion of the colon must have con-

tributed severely to the shock and the rapidly spreading bilateral pneumonia is significant of the complete breakdown in his resistance to infection. The surgical procedure itself appeared faultless. The patient was technically cured of his carcinoma, and the small localized suture abscess would not have caused any trouble.

GENERAL DISCUSSION

DR. HARDYMON: Do you think a pulmonary infarct could have preceded the necrotizing pneumonia?

DR. J. L. MORTON: I don't think those hilar shadows suggest infarction.

DR. VON HAAM: The oliguria and uremia of the patient are a prerenal phenomenon. There was no actual damage done to this particular kidney. The thrombus decreased the circulation of the kidneys but did not cause an infarction.

DR. HARDYMON: Dr. von Haam, how do you feel about this so-called "hepato-renal" syndrome? Do you think that the liver changes were important?

DR. VON HAAM: No, the only surgical hepato-renal syndrome I recognize, without being able to explain it, occurs in patients with jaundice who have undergone surgery involving the gallbladder, bile ducts and head of the pancreas.

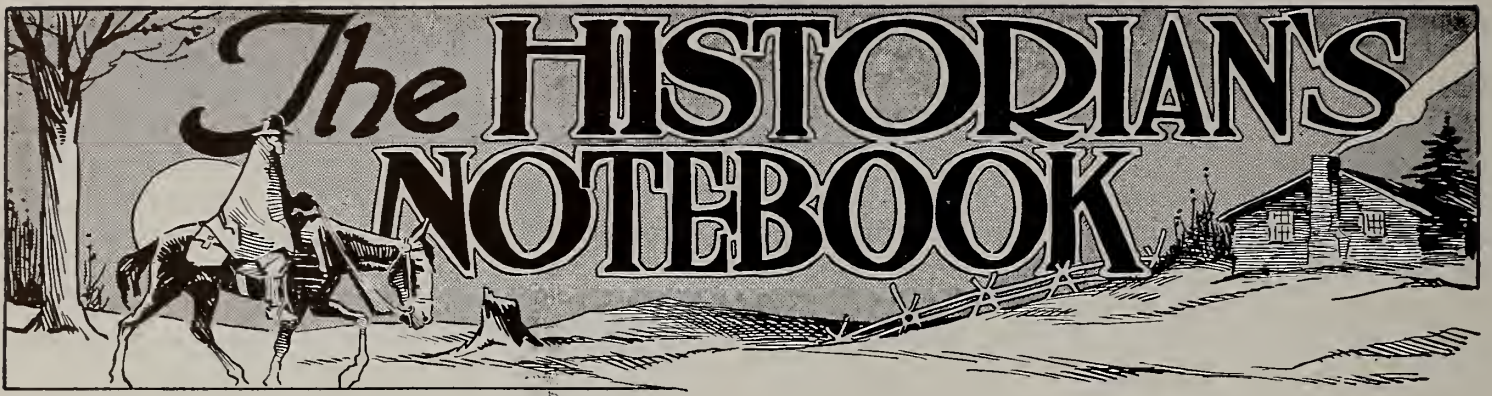
MEDICAL STUDENT: Dr. Hardymon, why don't they administer anticoagulants after surgery in order to prevent thrombosis and embolism?

DR. HARDYMON: Such therapy could cause other difficulties, such as severe late postoperative hemorrhage, and it is better not to chance it.

The Treatment of Amebiasis With Wide Spectrum Antibiotics

Incorporation of the wide spectrum antibiotic drugs as intestinal amebicides invokes a new therapeutic concept in which these agents theoretically potentiate a four-fold action: (1) amebic inanition, by disturbance in bacterial flora, (2) control of secondary infection, (3) nullification of invasive bacterial aid to the amebae, and (4) direct amebicidal action.

Of the antibacterial antibiotic drugs, erythromycin and terramycin® are endorsed either as conditioning agents or true amebicides. Of the restricted bacterial spectrum antibiotic agents, fumagillin is an excellent amebicide. Anisomycin, potent in vitro, will require more extensive clinical evaluation before its efficacy and innocuousness can be established. Two newer chemical agents, Win 12051 and triamar under preliminary study have been indicated as potent amebicides.—Gordon McHardy, M. D., Donovan C. Browne, M. D., and Robert J. McHardy, M. D., New Orleans: *J. Louisiana State M. Soc.*, 108:49, 1956.



Rise and Decline of Freudianism

MAX SEROG, M. D.

PART I

A TRUE history of psychoanalysis has not been written. Perhaps the time is not ripe as yet for a matter-of-fact approach to psychoanalysis, which was from its beginning the topic more of emotional than of logical argumentation. A history of psychoanalysis should depict objectively the course of events, lay bare its various roots, and reveal its cultural aspects. Freud's *History of the Psychoanalytic Movement* is but a selection of events, seen and presented from the psychoanalytic viewpoint.

More than half a century ago psychoanalysis made its appearance. It started from observations in hypnosis.

At the end of the last century the French neurologists Charcot, Libeault and Bernheim treated hysterical symptoms with hypnosis, utilizing its increased suggestibility to provoke or to abolish hysterical symptoms. In Germany at this time hypnosis was much discussed, used by some, but generally rejected. The famous brain anatomist Meynert in Vienna denounced the treatment with hypnosis as not scientific and called it "a psychical epidemic among doctors" (quoted by Ernest Jones). (In 1913, at the Congress of German Psychiatrists in Breslau, I heard Hoche-Freiburg use the same phrase about psychoanalysis.)

HYPNOSIS THE BEGINNING

Freud started with hypnosis in the same way as he had seen it with Bernheim and Charcot. But Freud found out that hypnosis offers other possibilities than its increased suggestibility. Around 1890 Freud, together with the Viennese physician Breuer, treated with hypnosis a girl who suffered from hysterical symptoms. While in a state of hypnosis the girl started to talk about previous highly emotional situations related to her hysterical symptoms. These situations, forgotten before, were recalled during hypnosis.

Submitted September 13, 1955.

The Author

- Dr. Serog, Dayton, is a member of the staff of the Dayton State Hospital.

The recollection was accompanied by a vehement outburst of emotions and was followed by the disappearance of the symptoms.

This procedure, later developed by Frank in Zurich, became known as the "Cathartic Method." Used in proper cases and with appropriate technique, this method gives good results, especially in cases of nervous symptoms after psychic shock, as I know from my own experience. In and after both World Wars this method was employed for the treatment of soldiers and veterans with nervous disturbances on both sides of the front (W. Brown, M. Serog).

The fact that hysterical symptoms are of psychic origin and can be abolished by psychical means was well known at this time. Charcot in Paris, whose "Lecons du Mardi" (Lectures of Tuesday) Freud attended and translated into German, realized that hysterical symptoms originated from affective ideas. Janet had found that previous emotional experiences, although they seemed to be forgotten, may produce hysterical symptoms. Hysterical patients, says Janet, "suffer from reminiscences." When they were forgotten deep hypnosis had to be employed to make them re-emerge. But deep hypnosis was not always possible. Confronted with failures with deep hypnosis, Freud began to replace the hypnosis with free associations produced in a state of relaxation, to dig out affective complexes. The patient had to lie down with closed eyes, to relax, and then freely to talk about everything that just came into his mind. This was Freud's "concentration technique," "which I later elab-

orated into a method" (Freud, quoted by E. Jones).

The new method was gradually improved. Freud termed it "psychical analysis." The term *Psychoanalysis* appears for the first time in 1896 (Jones).

With his new psychotherapeutic procedure Freud attained good results and made important psychological observations. Freud then tried to explain both his results and his observations through a speculative theory. He constructed this theory through "implications of unjustifiable interpretation into observed data" (Woodworth).

TRENDS OF THE TIME

The French authors, frequently mentioned, were at this time the vanguards of currents in psychology which just were beginning to reach other parts of the European Continent. In Germany physiological psychology was still considered the only psychology, and the new experimental psychology was saluted with great hopes.

The middle of the nineteenth century was the climax of a philosophical attitude known as "materialism." It was the denial of the existence of anything immaterial. The materialistic approach to world and life turned away not only from all transcendental, but from all spiritual subjects. There was only matter. The existence of anything psychical was denied. Ideas were supposed to be "secretions of the brain, as the urine is a secretion from the kidney" (Buechner).

In medicine similar trends prevailed. Everything that was not physically substantiated did not exist. Complaints of a patient without organic lesions were not disease and not worthy of discussion. An over-estimation of pathological anatomy resulted. The interest of the physician in the patient ended when the diagnosis was established and began again when the autopsy was performed.

At the end of the nineteenth century the counter-movement started, the pendulum began to swing to the opposite side. The one-sided physical approach was felt unsatisfactory. The interest in psychic phenomena awoke again. Psychotherapy was revived. While hysteria before meant but naughtiness, now the neuroses were brought out of the corner of neglect to the foreground of general attention. Hypnosis and suggestive methods were practiced as treatment of hysterical symptoms.

Corresponding reactions were noticeable in other fields. In German literature and art, the "naturalism" of the preceeding era was followed by a special brand of Romanticism and Mysticism.

In the time of its origin, psychoanalysis was one of the reactions against the purely physical approach in medicine. Psychoanalysis was the first conscious attempt to approach psychic phenomena in a psychic way, not from without, but from within. This way, however, is not causal explanation, it is imaginative, empathetic

psychic understanding of psychic motivations and connections.

But here psychoanalysis failed in its first beginnings. Freud, who had learned the psychotherapeutic possibilities of his cathartic method, and whose gift of psychic understanding accomplished much with the new instrument of his psychoanalytic procedure, now constructed a theory to render account for his results. This theory, objectionable from many angles, is an attempt to rationalize psychic understanding. But psychic understanding is not accessible to a rational-intellectual approach and cannot be explained causally.

Psychoanalysis, which had originated as a reaction against a one-sided rationalistic intellectualism, could not strip off entirely the egg shells of its birth; it had to pay its tribute to the time of its origin. Psychoanalysis, which had marched out to crush the old idols, finally erected many of them in new temples.

ONE MASTER

Freud had conceived his theory as a dogmatic entity. For a long time he kept psychoanalysis for himself. "For ten years," says Freud, "I was the only one occupied with it."

Psychoanalysis was conceived and designed as an entity. Therefore it could not be changed essentially without destroying it. Freud knew it. "Psychoanalysis is my creation," he says. The psychoanalytic doctrine did not develop, it was "created." Although enlarged later, it sprang from the head of its creator as Athena from the head of Zeus.

Freud felt himself the guardian of the pure doctrine and the highest authority to determine its rule and application. "I feel myself justified in assuming that nobody knows better than I what psychoanalysis is, what its name should cover." Freud's autocratic attitude did not tolerate criticism, not even a constructive criticism as in the case of Bleuler.

Freud attempted in an unprecedented way to determine the later fate of his doctrine. His desire to preserve the pure dogma and resentment against a vehement and not always fair opposition made Freud create the psychoanalytic movement and the psychoanalytic societies.

Freud's procedure, which took psychoanalysis out of the discussion of general medicine and made the psychoanalytic societies a kind of strictly disciplined sect for the preservation of the true faith, cannot be fully explained by the strong opposition of official medicine to psychoanalysis. There had been other methods in medicine, which originally came to it as uninvited outsiders and were first rejected as intruders, e.g. hydrotherapy and electrotherapy. These methods, however, were gradually amalgamated and, through mutual influence, finally absorbed into clinical medicine. Freud's segregation of psychoanalysis from clinical medicine, blocked

such natural development from the beginning. So psychoanalysis remained encapsulated like a foreign body within the organism of medicine. Freud's rigid theory and the rigid attitude he gave to his psychoanalytic organization rendered impossible the natural absorption of psychoanalysis into clinical medicine. Psychoanalysis remained the illegitimate child, tolerated, but not recognized by the family of medicine.

GERMAN OPPOSITION

From the beginning the new movement met with strong opposition. Official psychiatry in Germany was strictly opposed to the new doctrine. First it attempted to suppress it. At the convention of German psychiatrists in 1910 it was forbidden to practice psychoanalysis in sanitariums. However, German psychiatrists wanted to clarify their attitude toward the new teaching. The convention of German psychiatrists in Breslau in 1913 was entrusted with this task. The main topic of the meeting was "The Value of Freud's Psychoanalysis." Bleuler (Zurich) spoke pro, Hoche (Freiburg) con. I was assigned by the *'Medizinische Klinik'* to report the convention for that Journal.

Today, after more than 40 years, I still remember distinctly the unusual atmosphere of high tension and heated indignation in which the convention started. Bleuler weighed his viewpoints carefully. He rejected the structure of the psychoanalytic theory, but he recognized some details as a progress in psychological understanding. He also recognized the importance of unconscious phenomena, but rejected Freud's theoretical ideas of the "Unconscious." Bleuler demanded that indications and contraindications for psychoanalytic treatment should be found and fixed.

Hoche assailed the way of thinking in psychoanalysis as not logical and not scientific. He objected to Freud's generalization of some correct facts and to Freud's equalization of analogy and identity. He attacked sharply Freud's concept of sexuality and condemned the intrusion of laymen into a medical treatment, favored by Freud. Hoche believed that an essential reason for the expanding new teaching was disillusionment about experimental psychology. Many who had greeted it with great hopes now turned away disappointed and embraced the new doctrine.

In the first phase of psychoanalysis it was mainly Freud's sex concept which evoked vehement opposition, yes, stormy indignation. Such indignation was, of course, not a matter-of-fact criticism, and Freud and the psychoanalysts were right when pointing to the emotional source of such indignation. However, they reacted not less emotionally to any criticism of psychoanalysis. It became a fixed pattern to repudiate such criticism as "resistance." So for them psychoanalysis became still more an unassailable dogma. For he who agreed, confirmed it; who disagreed,

confirmed it through his "resistance." However, the level of the criticism aimed at Freud's doctrine was rather low. Bjerre, a follower of Freud but critical against "the blunder of Freud's theory" stated just the same: "I consider the teachings more valuable than the shallow criticisms which have been directed against them."

The wave of indignation which Freud's emphasis on sex matters had evoked ebbed slowly. A new opposition arose against the non-rational, unscientific method of psychoanalysis.

DOUBLE-FACED PSYCHOANALYSIS

Such opposition, however, saw only one side and not the double-faced aspect of psychoanalysis. If psychoanalysis really had been nothing but a new psychotherapeutic attitude, looking upon psychic phenomena from within and utilizing imaginative, empathetic psychic understanding, then it would have stood outside of logic and science and neither need interfere. However, along with his fruitful psychotherapeutic attitude, psychoanalysis pretended to be science, behaved like science, and made the futile attempt to underpin its psychotherapeutic attitude through the construction of a rationalistic-intellectualistic theory.

Not the non-rational trends in psychoanalysis, but its unseparable mixture of rational and non-rational features is the most objectionable part of psychoanalysis.

Freud presented from the beginning his theory as science and attempted a causal explanation for everything, yes for any psychic subtlety. This becomes possible only through a steady confusion of "cause" and "motivation," which lies at the bottom of the whole psychoanalytic theory. Through a permanent interchanging of the meaning of "cause" and "motivation" the causal law of the physical world is applied to the psychic aspect of emotions, they become endowed with physical properties like measurable quantities, and even love becomes a quantity which can be transformed like an electric current.

In Freud's theory, there is lack of sharp delineation and clear definition. Words, frequently used, cover at different times different meanings. Undue generalization and undue simplification results in an impressive, but deceptive presentation of complicated mental functions.

Freud's concept of the "Unconscious," the main pillar of his theory, met with frequent criticism. Hardly anybody doubts that there are unconscious and subconscious phenomena. But there is not and cannot be "The" unconscious which acts and behaves like a human being.

DREAMS

In Freud's concept the unconscious directs and controls the dream. But the dream is not directed and controlled at all. The dream is a state of mental disintegration, a state of uncontrolled emotionality. The suspension of all controlling and directing thinking is the most significant fea-

ture of the dream. The performance which Freud ascribed to the unconscious during sleep and dream would be a respectable achievement even for our awake mind.

Freud's dream theory is but the application of his general theory to the dream. However, as objectionable as Freud's dream theory is, the dream phenomena described by him (e. g. displacement and condensation) exist and can be confirmed by observation. But all these dream phenomena—and much more in the dream phenomenology, not considered by Freud—can be understood through the primitive thinking which prevails in the dream. Phenomena like condensation are found wherever primitive thinking prevails—in dreams, in primitive tribes, in small children, in art, in schizophrenics. (Serog) Freud's theory is objectionable also for methodological reasons, that is because of the way he arrived at it. In Freud's writings assumptions become a probability; a while later they are a proved fact from which general rules are derived. Frequency of occurrence becomes a law of occurrence, which then is dogmatized as a fixed theory and finally canonized as an indisputable truth.

Psychoanalysis continued to live in segregation in the psychoanalytic societies. There, too, criticism was permitted only as long as it did not touch the foundation of Freud's doctrine. Who questioned the dogma was banned. Adler, Jung, and Stekel are cases in question.

ADLER'S POSITION

Adler looks instead upon the explaining cause, upon the final purpose. The neurotic symptom becomes understandable as "arrangement"; psychotherapy has to find out its true meaning and has to unmask it. To do this in the right way and in the right moment is an essential part of psychotherapy.

Adler's "Guiding Line" (Leitlinie which comprehends the directing individual trends) became a fruitful psychotherapeutic conception. Not less important for psychotherapy was Adler's realization that the endeavor to overcome individual shortcomings through compensation may foster valuable individual qualities; weakness may become the peacemaker for strength. Adler's concept of constitutional functional inferiority of organs and of the "Language of the Organs" (the relationship of certain organs to certain affects) became important for the understanding of the organ neuroses. In his theory, Adler substituted Freud's one-sided sex concept with his—not less one-sided—theory of the "will for power." The unconscious, the essential pillar of Freud's construction is in Adler's concept still present, but plays an accidental and insignificant role. Adler's concept contains some new important psychological observations, useful for psychotherapy.

Adler's ideas were later absorbed by psycho-

analysts and used by many who did no longer know their origin. Later, psychotherapy in this country became almost identical with psychoanalysis; psychoanalysis being identical with Freud, the creator of psychoanalysis got credit for ideas which once he had strongly attacked.

(To be concluded in May issue)

Wanted: Historical Information On William Maclay Awl

In the Historian's Notebook of September 1955 there appeared an article entitled "Ohio Psychiatric Pioneer—William Maclay Awl (1799-1876)," by Dr. Philip C. Rond, of Columbus.

Dr. Awl was one of the pioneers among Ohio physicians who were interested in care of the insane. He worked very diligently with Dr. Daniel Drake for the establishment of a Lunatic Asylum. He became the first Superintendent of the Ohio Lunatic Asylum at Broad and Washington, Columbus, Ohio, and was very active in the founding of what is now the American Psychiatric Association.

The article in *The Journal* created considerable interest, particularly among physicians interested in the development of psychiatry in Ohio, and it has been suggested to Dr. Rond that he collect additional information on the subject. He is exceedingly anxious to do so and to that end has requested persons who have data on Doctor Awl to communicate with him. Dr. Rond may be contacted at the Columbus Receiving Hospital, Ohio State University Health Center, Columbus.

Medicinal Use of Plants and Herbs In Olden Times

German physicians of 1562 were told in *Kreuterbuch*, an herball of the time, that celery seeds, really the diminutive ripe fruits, have diuretic and antispasmodic properties. Along with other common vegetables, such as dandelions and asparagus, it was recommended for use as a medicine with diuretic properties.

Celery is originally native to Europe, but was introduced to this country, where it thrived, at an early date. It is a casual, but hardly persistent, escapee from gardens. In other words, it is known to grow wild as well as under cultivation.

The American Indians used 1,100 plants and herbs, maintaining Nature did and always would provide a herb for every ill—but the colonists brought more. The Spice Trade became the Drug Trade—Ginger, clove, nutmeg, pepper and mustard vied with the mild decoctions of roots and herbs; sassafras, mandrake, flowers, and leaves—all found a place in the spring cleansing program.

Also, in the early days of this nation, partridgeberry wine—fortified with port and good sherry wine—supplemented the household store of supplies for health restoration.

Medical Education Week . . .

Medical Association and Association of Medical Colleges Combine Forces To Support Medical Schools; Grass Roots Cooperation Asked

THE first nationwide observance of Medical Education Week, April 22-28, is a joint undertaking of the American Medical Association, the Association of American Medical Colleges, the National Fund for Medical Education and the American Medical Education Foundation.

Specifically, Medical Education Week has three functions: (1) to focus national attention on the significance of medical education and the problems of the medical schools; (2) to bring home to the public the contributions of medical science to American Life, and (3) to foster public interest, through wide public knowledge, in the private support of medical education.

Co-ordinating committees, representing the sponsoring groups, are being formed in the various states and communities throughout the country. The story of the progress of medical education will be brought to the public through the various communications media, such as newspapers, magazines, television and radio.

STATE COMMITTEE

Dr. Charles L. Hudson, President of the Ohio State Medical Association, has named Dr. Carl A. Wilzbach, Cincinnati, Chairman of the Committee on Education of the OSMA, to head up Ohio's Medical Education Week Committee. Other members of the committee are: Dr. Charles A. Doan, Dean of the Ohio State University College of Medicine, Columbus; Dr. Joseph T. Wearn, Dean of the School of Medicine, Western Reserve University, Cleveland; Dr. Stanley E. Dorst, Dean, University of Cincinnati College of Medicine; the following members of the OSMA Committee on Education: Dr. J. L. Webb, Nelsonville; Dr. Ian B. Hamilton, Canton; Dr. Charles S. Higley, Cleveland; and Dr. Eugene A. Ockuly, Toledo; and Mrs. Victor R. Frederick, Urbana, representing the Woman's Auxiliary to the OSMA.

Each county medical society has been asked to designate a local chairman to promote MEW week locally. Local chairmen have been furnished "idea" kits which contain numerous program suggestions, publicity materials, sample scripts, speeches, interviews, proclamations and newspaper releases.

At the invitation of the Armed Forces Institute of Pathology, Dr. Edward A. Gall, of the University of Cincinnati, spent a week as consultant at the institute, Walter Reed Medical Center, Washington, D. C. While there he addressed the institute's staff on "Hepatic Cirrhosis in Association with Inborn Errors of Metabolism."

Rehabilitation Programs in Need Of More Trained Personnel

A nationwide shortage of trained workers is preventing the benefits of modern rehabilitation reaching vast numbers of the nation's disabled. This was one of the conclusions in a report released by the Health Resources Advisory Committee of the Office of Defense Mobilization.

The report estimated the national supply of physical therapists at 7,300 and a need of approximately 12,500 and the national supply of occupational therapists at 3,700 as compared to a need of approximately 9,500. To meet the nation's needs for medical and psychiatric social workers, the report said, would require graduation of 800 to 1,000 new medical social workers and 1,000 new psychiatric social workers each year. It added that no adequate estimate could be made at this time of the national need for clinical and counseling psychologists, speech and hearing therapists, and rehabilitation counsellors, but the need now far outstrips the supply.

The report said that through its current programs the Federal government had adequate mechanisms to meet its responsibility for assisting in increasing the national supply of such personnel and added that no new Federal legislation for this purpose was needed at this time.

The major Federal programs to aid in the recruitment and training of such personnel are those operated by the Public Health Service and the Office of Vocational Rehabilitation, Department of Health, Education and Welfare. The report indicates that further Federal support designed to increase the national supply of such personnel should come through increasing the funds available to the Public Health Service and Office of Vocational Rehabilitation to expand existing programs.

Cincinnatian To Speak at Proctologist Meeting

Dr. H. A. Springer, Cincinnati, will give a paper at the Eighth Annual Convention of the International Academy of Proctology, Drake Hotel, Chicago, April 23-26. His subject will be "Why Do Pilonidal Cysts Recur?" Dr. Springer is a trustee of the Academy. Another Ohioan who is active in the work of the International Academy is Dr. Miles T. Hoerner, councilor for Ohio. Further details of the program may be obtained from Dr. Alfred J. Cantor, secretary of the organization, at 147-41 Sanford Ave., Flushing 55, New York.

Polio Vaccine . . .

Short Supply Cause of Most of the Problems and Confusion; Here Are Facts and Figures on How Ohio's Portion Has Been Distributed

By CHARLES S. NELSON, *Executive Secretary*

IN the maze which surrounds the so-called polio vaccine puzzle, one fact stands out predominately: Not enough vaccine has been produced or is being produced to meet the needs.

This fact more than any other single thing or combination of circumstances and facts is responsible for the problems, confusion and misunderstandings which have accompanied the entire polio vaccination program here in Ohio and throughout the country.

None other than Congressman J. Percy Priest, chairman of the House Committee on Interstate and Foreign Commerce which committee handles medical and health matters, supports the above statement. In a statement in the Congressional Record of March 15, 1956, Mr. Priest said: "Every day more parents come to realize that only small amounts of poliomyelitis vaccine—falling far below present needs—are available in the communities for the vaccination of children under the age of 20 and expectant mothers, constituting the priority group." (Mr. Priest could have used the figures 1 to 10 as the age group and still have been correct in his observation.)

FOLSOM NOT OPTIMISTIC

On or about the same date, Secretary Folsom of the Department of Health, Education and Welfare, in a press interview said: "It is likely to be many months before enough vaccine will be available to provide the recommended three injections to all who need it," adding that "accurate predictions of future supplies are impossible." The statement was made after he had met with representatives of certain pharmaceutical firms.

Additional supporting evidence that the supply of vaccine is quite limited comes from the U. S. Public Health Service which has asked physicians to postpone the booster shot (third shot) temporarily "to enable more children to receive the first and second doses and thus extend protection to more people before this summer's poliomyelitis season." This recommendation received the support of the National Foundation for Infantile Paralysis.

FACTS—NOT A DEBATE

The purpose of this article is to present facts—facts relating to the situation in Ohio, primarily—not to engage in a debate as to whether certain policies and procedures are good or bad;

whether or not Congress should have kept its hands out of polio picture; whether or not it got into politics; whether or not the job has been bungled and if so, by whom, etc.

An effort will be made to show why most Ohio physicians have not been able to get an unlimited supply of vaccine; to review procedures which have been initiated in Ohio to distribute the available supply of vaccine; to present figures on the amount of vaccine made available to the counties through commercial channels and to the public health agencies; to mention a few of the administration problems involved.

Let's take a look at the record here in Ohio.

HOW OHIO'S SHARE IS SET

Under Federal Regulations controlling the production and distribution of the polio vaccine, vaccine is allocated to the states on a formula basis. The amount allocated to Ohio is based on the number of children in Ohio in the age range of zero to 20 and pregnant women. On this calculation, Ohio is eligible to receive approximately five per cent of all the vaccine released for sale by polio vaccine manufacturers after clearance with the Federal Government. The decision as to how much shall be released for sale through commercial channels and how much shall be purchased with Federal funds and distributed to public agencies rests with the State Director of Health, Dr. Ralph Dwork.

Because of the short supply of vaccine, Dr. Dwork with approval of his advisory committee has recommended that inoculations be limited for the time being to children from one year through 10 years and pregnant women.

ONLY ENOUGH FOR 40% OF NEED

Excluding children who have been vaccinated under the National Foundation program in the schools, Ohio has approximately 1,243,399 children in the one through 10 age group. Officials estimate that there are about 220,000 pregnancies in Ohio each year. This makes a total of 1,463,339 persons eligible for vaccination.

Obviously close to 3,000,000 cc. of vaccine would be required to provide two inoculations for each person in the group. Ohio todate has received only about 40 per cent of the total amount required to do the job.

The figures shown in Table No. 1, secured from the Ohio Department of Health, reveal the amount

of vaccine received by Ohio per month since August 1, 1955, when distribution of the vaccine was resumed after a suspension of several months by order of the Federal Government.

Also, the table breaks down the allocation each month as to public agencies and as to commercial channels.

COMMERCIAL TRADE GETS 59%

Table No. 1 shows that the amount of vaccine received by Ohio from August 1, 1955, to March 20, 1956, totals 1,203,298 cc.

Of this total, 702,469 cc. or about 59 per cent have been released by the Ohio Department of Health for sale through regular commercial channels.

During the same period, 500,829 cc. have been purchased by the department with Federal funds and made available to public agencies, primarily local public health departments. This distribution amounts to approximately 41 per cent of the total.

Because of a requirement that each vaccine manufacturer when making a sale to a pharmacy or physician must file a copy of the invoice with the Ohio Department of Health, the department is able to supply statistics on the distribution of the vaccine sold through commercial channels.

SALES OF VACCINE BY COUNTIES

Table No. 2 shows where 553,170 cc. of the 702,469 cc. of vaccine allocated for sale through commercial channels were sold. The tabulation was prepared before invoices on the sales of other quantities had been received by the department.

Table No. 2 also presents a breakdown by county of the estimated number of children in the one through 10 age group now being recognized as the priority group for inoculation.

THE FEDERAL ACT

Under the Federal Poliomyelitis Vaccination Assistance Act of 1955, (re-enacted early in 1956 to run until July 1, 1957), Congress appropriated \$30 million for distribution to the states. This was to be used for the purchase of vaccine for programs under the direction of public agencies. The Federal act specifically prohibits the application of a "means test" in the use and distribution of the vaccine purchased by Federal funds and allocated to public agencies.

Under this Federal program, Ohio received \$1,072,920 which could be used for the purchase of vaccine for use by the public agencies. No state money is available for this.

CAN BE ALLOCATED TO PHYSICIANS

There is nothing in the law or the policy regulations to prohibit a local health department from making the vaccine available to physicians in private practice. Many of the Ohio health departments are doing so. The only prohibition is that no charge can be made for the vaccine itself.

A charge can be made, if the physician wishes, for the giving of the shots.

In the Fall of 1955, the Ohio Department of Health and the Polio Advisory Committee estimated that approximately 80 per cent of the children eligible for inoculations would desire to secure vaccination from their own private physician and that about 20 per cent would request vaccine from their local health department.

Therefore, it was recommended that a policy be followed which would provide that 80 per cent of Ohio's share of the vaccine be released for sale through normal commercial channels and that the balance be purchased for use and distribution through local health departments. Obviously, this recommendation was made on the assumption that the supply of vaccine would be adequate to meet the need.

UNABLE TO MAINTAIN 80-20 RATIO

The department has never been able to maintain the 80-20 ratio for several reasons: (1) short supply of vaccine; (2) irregularity in the releases of the vaccine; (3) problem of out-dating resulting from long period from time of production of vaccine to release by Federal Government (sometimes requiring a minimum of 120 days); (4) fluctuation in the demand on the part of the public; (5) heavy requests for vaccine from many health departments after concluding the NFIP school vaccination program; (6) pickup of interest on the part of the public in the vaccination program as publicity about the approaching polio season was released; (7) increase of requests received by private physicians from patients wishing vaccination after the public health programs had started.

DISTRIBUTION TO HEALTH AGENCIES

Table No. 3 shows how 380,131 cc. of the 500,829 cc. of vaccine purchased for use and distribution of local health departments were distributed to the various local health departments of the state. Some of the vaccine which has been purchased for the health departments had not been distributed when the tabulation was completed.

It will be noted that some health departments have not received vaccine. There are various reasons for this. In some instances, the department has not filed a request with the state department. In others, the request of the local agency was received many weeks after the bulk of the requests had been received. Requests are filled in the order received. Several local departments filed a request but asked that the vaccine not be sent until later when the agency would be better prepared to administer the program.

As of March 20, vaccine had been distributed to 100 of the 158 operating local health units of the state. An effort will be made to send

TABLE NO. 1
AMOUNT OF VACCINE RECEIVED IN OHIO FROM AUGUST, 1955, TO MARCH 20, 1956

Month	Amount Available	Purchased for Public Agencies	Percentage to Public Agencies	Released for Commercial Distribution	Percentage to Commercial
August	266,052 cc	86,934 cc	32%	179,116 cc	68%
September	93,843	28,152	30%	65,691	70%
October	135,018	62,217	46%	72,801	54%
November	87,492	87,492	100%	-----	-----
December	173,646	-----	-----	173,646	100%
January	52,326	-----	-----	52,326	100%
February	253,549	150,651	59%	102,898	41%
March (to 20th)	141,372	85,383	60%	55,989	40%
Totals	1,203,298 cc	500,829 cc	41%	702,469 cc	59%

some vaccine from new supplies into each of the 58 units which have not been supplied heretofore.

WHAT ABOUT THE FUTURE?

What's the outlook for the balance of 1956 regarding the polio vaccine supply? To be blunt, the outlook is spotty.

Officials are hoping that steps being taken to greatly increase production and speed up testing and approval procedures will bring about a big increase in the supply—produce at least two shots for all in the present eligible groups before the start of the new polio season. Nevertheless, they are cautious in making predictions.

For this to be accomplished in Ohio, more than twice the supply of vaccine received so far will have to be made available. Whether this can be done remains to be seen.

WHAT FEDERAL OFFICIALS SAY

Some idea as to the contingencies involved in the production and distribution of the vaccine is found in excerpts from a report of the House Interstate and Foreign Commerce Committee (Congressional Record of March 15, 1956), drafted after the committee had been taken on a tour of inspection of the Eli Lilly & Co. plant at Indianapolis. Said the report in part:

"In the course of the hearings, the Surgeon General of the Public Health Service, Dr. Leonard A. Scheele, furnished the committee, upon its request, estimates of anticipated production of vaccine during the year 1956. It was estimated that during the calendar year 1956, approximately 166 million net cubic centimeters of vaccine might become available for use. This amount, plus approximately 30 million cubic centimeters released prior to January 1, 1956, would make a total of 196 million cubic centimeters available by December 31, 1956. This quantity would suffice to make 3 injections available for each of the 65 million children under age 20 and expectant mothers, constituting the priority groups.

"In furnishing these rough estimates Dr. Scheele cautioned that the figures submitted by him were subject to many contingencies. Dr. Scheele pointed out that the difficulty of making the vaccine was one of the principal factors which make it in-

advisable to attempt to make firm projections or to place too much reliance in the accuracy of such estimates.

* * *

PRODUCTION PROBLEM

"The visit to Eli Lilly's vaccine manufacturing facilities has provided the committee with a unique opportunity to gain some insight into the reasons why it is not a simple matter to step up production of the Salk vaccine. The biggest problem in expanding operations is obtaining trained personnel. The principal, and perhaps only, source from which such personnel can be secured on short notice is from other programs of the Lilly Co. The committee is gratified that the Lilly Co. has decided to take this important step.

"Since the testing of vaccine fluid has failed to keep pace with production of vaccine fluid, the Lilly Co. has accumulated a considerable backlog awaiting testing. The company expected to complete its tests on this backlog by November 1, 1956. In view of the great need for additional vaccine supplies, the company, by shifting personnel, now expects to complete tests on this backlog by June 30, 1956. It is now the goal of Eli Lilly & Co. to test 60 million doses during the first 6 months of this year. This goal is 20 million doses greater than the amount of vaccine previously scheduled for completion by June 30, 1956.

"Eugene N. Beesley, president of Eli Lilly & Co. who gave the committee these estimates, cautioned, however, just as did Dr. Scheele in submitting his estimates, that unforeseen delays may occur in the testing procedure which might cause vaccine actually available for use by June 30, 1956, to fall well below this goal.

"Secretary of Health, Education, and Welfare Marion B. Folsom, after conferences with each of the five manufacturers of polio vaccine, has reported that several manufacturers were taking steps, involving additional personnel and equipment, in an effort to increase their output. However, he states accurate predictions of future supplies are impossible.

* * *

"The committee believes that the American people would rather suffer a slight delay in

present vaccination programs than see the programs jeopardized in any way by a recurrence of events which led to the suspension of vaccine approval by the Federal Government in April 1955."

TABLE NO. 2

DISTRIBUTION OF POLIO VACCINE THROUGH COMMERCIAL CHANNELS TO FEB. 29, 1956, AND CHILDREN 1 TO 10 YEARS, EXCLUSIVE OF THOSE WHO WERE VACCINATED IN N. F. I. P. PROGRAM IN SCHOOLS

COUNTY	Total cc Thru Commercial Channels	Population 1 - 10	Total N. F. I. P.	No. 1-10 Not Receiving N.F.I.P. Vaccine
Adams	144	4,626	798	3,828
Allen	4,572	18,769	3,922	14,847
Ashland	2,793	7,041	1,440	5,601
Ashtabula	5,112	16,912	3,762	13,150
Athens	2,298	8,309	1,602	6,707
Auglaize	2,658	6,671	1,518	5,153
Belmont	3,528	16,579	3,398	13,181
Brown	774	4,937	880	4,057
Butler	14,940	31,771	6,906	24,865
Carroll	513	4,398	742	3,656
Champaign	927	6,092	1,320	4,772
Clark	6,957	22,696	3,987	18,709
Clermont	3,471	10,383	2,703	7,680
Clinton	2,325	5,463	1,098	4,365
Columbiana	25,823	21,075	4,310	16,765
Coshocton	1,020	6,389	1,281	5,108
Crawford	1,878	8,378	1,812	6,566
Cuyahoga	111,753	260,966	65,137	195,829
Darke	2,091	9,337	1,719	7,618
Defiance	3,600	5,797	1,419	4,378
Delaware	2,178	6,106	1,348	4,758
Erie	4,596	10,882	2,378	8,504
Fairfield	3,912	11,063	2,298	8,765
Fayette	942	4,887	982	3,905
Franklin	41,856	92,526	24,631	67,895
Fulton	1,506	6,018	1,222	4,796
Gallia	1,731	5,488	989	4,499
Geauga	1,377	7,164	1,590	5,574
Greene	2,112	13,713	3,409	10,305
Guernsey	744	6,866	1,236	5,630
Hamilton	60,123	135,086	30,232	104,854
Hancock	4,812	9,479	1,870	7,609
Hardin	1,275	6,048	1,234	4,814
Harrison	387	3,966	753	3,213
Henry	1,107	4,784	1,024	3,760
Highland	1,944	6,118	1,017	5,101
Hocking	486	4,270	780	3,490
Holmes	552	4,775	677	4,098
Huron	1,245	8,831	1,960	6,871
Jackson	258	6,627	1,240	5,387
Jefferson	2,970	19,077	3,732	15,345
Knox	954	7,371	1,539	5,832
Lake	5,403	18,095	5,216	12,879
Lawrence	1,941	11,746	2,356	9,390
Licking	2,844	14,576	3,044	11,532
Logan	1,014	6,767	1,395	5,372
Lorain	9,480	31,629	8,216	23,413
Lucas	41,283	76,068	17,567	58,501
Madison	786	4,806	1,043	3,763
Mahoning	18,143	49,532	11,306	38,226
Marion	1,749	10,824	2,233	8,591
Medina	1,653	9,186	2,098	7,088
Meigs	414	5,205	969	4,236
Mercer	960	6,632	1,315	5,317
Miami	3,738	13,533	3,107	10,426
Monroe	105	3,078	509	2,569

COUNTY

	Total cc Thru Commercial Channels	Population 1 - 10	Total N. F. I. P.	No. 1-10 Not Receiving N.F.I.P. Vaccine
Montgomery	29,593	82,614	25,884	56,730
Morgan	480	2,623	428	2,195
Morrow	366	4,105	839	3,266
Muskingum	3,711	15,469	3,020	12,449
Noble	180	2,221	428	1,793
Ottawa	648	6,561	1,739	4,822
Paulding	51	3,418	724	2,694
Perry	216	6,126	1,144	4,982
Pickaway	1,104	6,364	1,193	5,171
Pike	612	5,221	1,498	3,723
Portage	2,976	14,486	3,520	10,966
Preble	834	6,264	1,385	4,879
Putnam	873	6,025	1,170	4,855
Richland	5,022	19,165	5,748	13,417
Rcss	3,153	12,480	2,398	10,082
Sandusky	1,713	9,843	2,107	7,736
Scioto	4,263	19,989	4,073	15,916
Seneca	2,952	11,482	2,599	8,883
Shelby	1,023	6,530	1,365	5,165
Stark	16,431	59,701	13,514	46,187
Summit	22,554	82,481	19,874	62,607
Trumbull	9,274	35,177	7,815	27,362
Tuscarawas	2,487	14,921	3,053	11,868
Union	1,185	4,618	887	3,731
Van Wert	2,691	5,657	959	4,698
Vinton	189	2,790	472	2,318
Warren	1,386	9,231	2,441	6,790
Washington	2,472	9,066	1,875	7,191
Wayne	3,432	13,275	2,409	10,866
Williams	2,214	5,481	1,283	4,198
Wood	4,806	12,205	3,015	9,190
Wyandot	522	4,348	879	3,469
Totals	553,170	1,619,350	376,008	1,243,342

TABLE NO. 3

DISTRIBUTION OF POLIO VACCINE, PURCHASED WITH FEDERAL FUNDS, TO LOCAL PUBLIC HEALTH DEPARTMENTS, TO MARCH 20, 1956

Health Department	cc. Received by Health Jurisdiction	Total cc. Received in County
Adams County	1,206	1,206
Allen County	-0-	-0-
Ashland County	405	405
Ashtabula County	-0-	-0-
Ashtabula City	-0-	-0-
Conneaut City	-0-	-0-
Athens County	-0-	-0-
Auglaize County	405	405
St. Marys City	-0-	-0-
Belmont County	6,345	-0-
Bellaire City	738	-0-
Martins Ferry City	1,080	8,163
Brown County	1,683	1,683
Butler County	3,537	-0-
Hamilton City	4,950	-0-
Middletown City	945	9,432
Carroll County	1,287	1,287
Champaign County	1,827	1,827
Clark County	4,095	-0-
Springfield City	4,158	8,253
Clermont County	-0-	-0-
Clinton County	2,205	2,205
Columbiana County	-0-	-0-
East Liverpool City	1,836	-0-
East Palestine City	405	-0-
Salem City	477	-0-
Wellsville City	-0-	2,718

Health Department	cc. Received by Health Jurisdiction	Total cc. Received in County
Coshocton County	-0-	-0-
Coshocton City	-0-	-0-
Crawford County	1,170	
Bucyrus City	-0-	
Galion City	792	1,962
Cuyahoga County	-0-	
Cleveland City	-0-	
Cleveland Heights City	306	
East Cleveland City	-0-	
Lakewood City	4,482	
Shaker Heights City	-0-	4,788
Darke County	-0-	-0-
Defiance County	-0-	-0-
Delaware County	5,977	5,977
Erie County	3,852	3,852
Fairfield County	2,016	2,016
Fayette County	-0-	-0-
Franklin County	10,872	
Bexley City	108	
Columbus City	16,686	
Grandview Heights City	-0-	
Upper Arlington	90	27,756
Fulton County	801	801
Gallia County	-0-	-0-
Gallipolis City	-0-	-0-
Geauga County	8,748	8,748
Greene County	12,339	12,339
Guernsey County	2,097	2,097
Hamilton County	8,028	
Cincinnati City	40,005	
Lockland City	-0-	
Norwood City	3,402	
Reading City	-0-	
St. Bernard	405	51,840
Hancock County	-0-	
Findlay City	900	900
Hardin County	1,410	
Kenton City	648	2,058
Harrison County	1,467	1,467
Henry County	1,077	1,077
Highland County	603	603
Hocking County	-0-	-0-
Holmes County	1,476	1,476
Huron County	3,528	3,528
Bellevue City	-0-	
Jackson County	-0-	-0-
Jefferson County	3,132	
Steubenville City	4,194	7,326
Toronto City	-0-	-0-
Knox County	-0-	
Mt. Vernon City	108	108
Lake County	6,003	
Painesville City	1,530	7,533
Lawrence County	4,806	
Ironton City	2,007	6,813
Licking County	3,240	
Newark City	1,889	5,129
Logan County	3,411	3,411
Lorain County	6,282	
Elyria City	2,808	
Lorain City	4,365	13,455
Lucas County	2,007	
Toledo City	14,066	16,073
Madison County	5,390	5,390
Mahoning County	-0-	
Campbell City	99	
Struthers City	1,422	1,521
Youngstown City	-0-	
Marion County	972	
Marion City	2,151	3,123
Medina County	4,050	4,050

Health Department	cc. Received by Health Jurisdiction	Total cc. Received in County
Meigs County	-0-	-0-
Mercer County	324	324
Miami County	4,068	4,068
Piqua City	-0-	
Monroe County	-0-	-0-
Montgomery County	7,506	
Dayton City	23,004	
Oakwood City	-0-	30,510
Morgan County	-0-	-0-
Morrow County	3,618	3,618
Muskingum County	2,367	
Zanesville City	2,403	4,770
Noble County	-0-	-0-
Ottawa County	-0-	-0-
Paulding County	-0-	-0-
Perry County	-0-	-0-
Pickaway	981	
Circleville City	90	1,071
Pike County	-0-	-0-
Portage County	4,302	
Kent City	1,044	5,346
Ravenna City	-0-	-0-
Preble County	2,079	2,079
Putnam County	-0-	-0-
Richland County	-0-	-0-
Shelby City	-0-	-0-
Ross County	-0-	-0-
Sandusky County	-0-	
Fremont City	-0-	-0-
Scioto County	-0-	
New Boston City	-0-	
Portsmouth City	1,764	1,764
Seneca County	1,881	
Fostoria City	1,017	
Tiffin City	-0-	2,898
Shelby County	3,132	3,132
Stark County	10,899	
Alliance City	1,800	
Canton City	3,150	
Massillon City	1,980	17,829
Summit County	6,279	
Akron City	21,726	
Barberton City	2,070	30,075
Trumbull County	4,653	
Girard City	-0-	
Niles City	1,800	
Warren City	4,716	11,169
Tuscarawas County	1,800	
New Philadelphia City	702	2,502
Union County	4,320	4,320
Van Wert County	-0-	
Van Wert City	-0-	-0-
Vinton County	-0-	-0-
Warren County	4,518	4,518
Washington County	-0-	
Marietta City	207	207
Wayne County	-0-	-0-
Williams County	801	801
Bryan City	-0-	
Wood County	3,096	3,096
Wyandot County	1,233	1,233
TOTAL		380,131 cc

When a city is not listed in its county of location, it indicates that the city has combined its health department with the county.





ACHROMYCIN*

Tetracycline Lederle

in the treatment of
respiratory infections

January and his associates¹ have written on the use of tetracycline (ACHROMYCIN) to treat 118 patients having various infections, most of them respiratory, including acute pharyngitis and tonsillitis, otitis media, sinusitis, acute and chronic bronchitis, asthmatic bronchitis, bronchiectasis, bronchial pneumonia, and lobar pneumonia. Response was judged good or satisfactory in more than 84% of the total cases.

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¹January, H. L. et al: Clinical experience with tetracycline. *Antibiotics Annual* 1954-55, p. 625.



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Proceedings of The Council . . .

Heavy Docket Considered at Meeting on March 11: Reports From Various Committees Studied and Approved; Plans for Annual Meeting Completed

A REGULAR meeting of The Council of The Ohio State Medical Association was held in the Columbus office on Sunday, March 11, 1956. All members of The Council were present except Doctors Atkinson and Woodhouse. Others attending were Messrs. Nelson, Saville, Page and Moore.

The Council, by official action, adopted a resolution relative to the illness of Doctor Atkinson, wishing him a speedy recovery.

The minutes of the meetings of The Council held on December 10 and 11, 1955, were approved.

MEMBERSHIP STATISTICS

Membership statistics were reported as follows by the Executive Secretary: Total membership in the Ohio State Medical Association as of March 9, 1956, 7,247, compared to a total membership of 8,633 as of December 31, 1955; number of OSMA members affiliated with the AMA as of March 9, 6,296.

PRORATING OF OSMA DUES

By official action, The Council authorized the prorating of OSMA dues for new members for the third and fourth quarters of 1956 as follows: Members joining in the third quarter of the year, \$15.00; members joining during the fourth quarter of the year, \$10.00.

REISSUANCE OF CHARTER TO DARKE COUNTY MEDICAL SOCIETY

By official action, The Council approved the reissuance to the Darke County Medical Society of a copy of its charter, the original having been lost, and instructed the Executive Secretary to present this recommendation to the House of Delegates in April.

SUMMIT COUNTY CONSTITUTION AND BY-LAWS

A copy of the revised Constitution and By-Laws of the Summit County Medical Society, approved by that society and submitted to The Council for action, was considered. On the advice of the chairman of the Judicial and Professional Relations Committee, Dr. R. Dean Dooley, Dayton, action was delayed, and Doctor Dooley's recommendation, that a conference be held with representatives of the Summit County Medical Society on the various revisions, was approved. Doctor Dooley had pointed out that quite a large number of the changes in the document needed clarification. The President designated Doctor Dooley, Mr. Wayne Stichter, legal counsel, and the Executive Secretary to meet with the Summit County Medical Society repre-

sentatives on this matter at a mutually agreeable time.

VAN WERT COUNTY CONSTITUTION AND BY-LAWS

Certain amendments adopted by the Van Wert County Medical Society to its constitution and by-laws were reviewed by The Council and approved by official action.

1956 ANNUAL MEETING

The Executive Secretary discussed the final arrangements for the 1956 Annual Meeting in Cleveland, April 10, 11 and 12. Reference was made to sessions at which The Council would be expected to be present and certain members of The Council designated as official hosts for some of the out-of-state guests.

It was decided that only the officers and their wives and certain out-of-state guests would be seated at the speaker's table at the annual banquet and that special tables on the floor would be reserved for the district Councilors and their wives. It was suggested that all members of The Council attend the banquet in formal dress inasmuch as they will be introduced.

HEADQUARTERS HOTEL FOR 1957 MEETING IN COLUMBUS

At the request of the Executive Secretary, The Council discussed the matter of a headquarters hotel for the 1957 meeting in Columbus, May 14, 15, 16. Most of the sessions will be held in the Veterans Memorial Building. By official action, The Council designated the Neil House as the headquarters hotel for the 1957 meeting.

REPORT FROM THE CANCER COORDINATING COMMITTEE

A report from the Cancer Coordinating Committee on a meeting of that committee held in the OSMA office on Sunday, January 8, 1956, was reviewed and discussed at length. By official action, The Council approved the report of the committee, reading in part as follows:

A meeting of the Cancer Coordinating Committee for the Ohio Cancer Registry was held in the office of the Ohio State Medical Association, Columbus, on Sunday, January 8.

Dr. James asked the committee to consider the advisability of revising the "Tumor Record" and "Follow-Up Report" to bring them into line with the forms of the American Cancer Society which have the approval of the American College of Surgeons and which are quite similar in content to the previously drafted Ohio forms. Mr. Veigel and Mrs. Lucas presented revised forms in line with the ACS forms. After

an extended discussion, the following actions were taken:

The "Tumor Record" form presented by Mr. Veigel and Mrs. Lucas was adopted with the following changes: More room for description of "Treatment"; printing of Reg. 257, pertaining to confidential information, at the bottom of the form; and printing on the back of the form "Follow-up Notes" for use of local hospital, clinic or cancer registry.

The "Follow-up Report" was adopted as submitted, with only one change, namely: Printing of Reg. 257 pertaining to confidential information at the bottom of the form.

The committee by official action agreed that the international coding system should be used by the central registry.

Mrs. Lucas discussed a form which could be used by the local cancer registry for securing follow-up information from attending physicians. The committee thought the form would be of value to local registries and recommended that it be produced in quantities for use by local registries, if they want to use it.

Dr. Dwork, Mr. Veigel and Mrs. Lucas reported that the "trial runs" in several areas had been completed and that they felt the operation of the central registry on a state-wide basis could now be started. Dr. Dwork stated that it would cost the Health Department about \$12,000 a year for salaries and wages of personnel which would be needed. This would not include costs of travel, equipment and printing.

It was agreed that special stationery should be provided for the project, carrying the name "Ohio Cancer Registry," location of the administrative office in the State Office Building, Columbus, name of Mr. Veigel as executive secretary, names of the sponsoring organizations and names of the members of the Coordinating Committee.

The committee agreed that a great deal of promotion and publicity would be required and that this should be done by the sponsoring organizations through articles in their publications, field work, talks to local groups, etc. It was decided that dates for talks before the following groups should be arranged: Ohio Society of Pathologists (Dr. Rappoport), Ohio State Surgical Association (Dr. James), Ohio Radiological Society (Dr. Hufford) and Ohio Academy of General Practice (speaker to be selected). It was agreed that the OSMA would print a story in *The Journal*, refer to the project in the *OSMAgram* and issue special bulletins to county medical society officers and cancer committee chairmen.

Mr. Veigel was asked to arrange an exhibit for the 1956 Annual Meeting of the OSMA in Cleveland, April 10, 11 and 12.

Dr. Rappoport said he felt one of the big problems in getting local registries set up would be that of financing, pointing to the problem in Youngstown as an example. Members of the committee said they believed that the Ohio Cancer Society through its local units could help meet this problem.

REPORT FROM THE COMMITTEE ON VETERANS AFFAIRS

The Council also approved a report from the Committee on Veterans Affairs with respect to a meeting of that committee held in the Columbus office on Sunday, January 29. Following is an abstract of the committee's report:

Members present reported on contacts with chairmen and local V. A. committees in their dis-

tricts. These reports indicated that there still are districts where initial contacts need to be made and that in other districts, attendance at the district conference has been only fair. The consensus was that the first job of the committee, namely, educating the profession on the V. A. problem, has only been started and that much work remains to be done.

The following comments and suggestions were made during the general discussion: Probably the best contact with local chairmen would be a personal visit. However, if this is not feasible, efforts should be made to hold a district conference, supplemented by phone calls and letters. In some places, the local V. A. committee chairman is indifferent to the problem or has little information about it. Some V. A. hospitals neglect to make reports to referring private physicians. Expansion of residency training in V. A. hospitals should be discouraged. Individual physicians should write to their congressman and to Ohio's senators concerning individual non-service connected cases receiving V. A. care and who can afford to pay for medical and hospital care. Opinion of all veterans should be secured on the V. A. problem.

REPORT FROM THE COMMITTEE ON MATERNAL HEALTH

Doctor Meiling and Mr. Page reported for the Committee on Maternal Health, which held meetings on February 19 and March 4. The committee reported that a subcommittee on anesthesia in obstetrics has been named by Doctor Ruppertsberg, the chairman of the committee. The purpose of this committee is to work out a practical solution to the problem confronting certain small hospitals on the matter of the administration of analgesia by nurses and to cooperate in providing postgraduate refresher work in anesthesiology.

Reference was made to the fact that an article by Dr. Jay Jacoby, Director of Anesthesia, Ohio State University College of Medicine, and prepared at the request of the committee, will appear in an early issue of *The Ohio State Medical Journal*. The article will summarize postgraduate opportunities in anesthesiology in Ohio.

The committee reported that it has reviewed, to date, 57 cases reported as maternal deaths—approximately one-half of the cases on file for the year 1955. In the near future the committee hopes to be able to present some statistical reports on its review of cases.

Also, the committee reported that a 16 mm, color film on Pudendal Block and a set of 2 x 2 Kodachrome slides on the same subject are now available through the Committee on Maternal Health for educational work on anesthesia in obstetrics. It was stated that the length of the film is approximately 13 minutes and that the set of slides numbered 44.

By official action, the report of the committee was approved.

REPORT FROM THE COMMITTEE ON PUBLIC RELATIONS AND ECONOMICS

Mr. Saville reported for the Committee on Public Relations and Economics, which met in the Columbus office on Sunday, January 15. By

official action, The Council approved the report and recommendations of the committee. (See Page 413.)

REPORT FROM JUDICIAL AND PROFESSIONAL RELATIONS COMMITTEE

The Executive Secretary reported for the Judicial and Professional Relations Committee with respect to a meeting of that committee held on Sunday, January 22. By official action, The Council approved the report and recommendations of the committee. (See Page 416.)

REPORT ON SERIES OF LECTURES ON GENERAL PRACTICE

Mr. Page reported on the series of lectures on general practice for senior medical students recently concluded at Ohio State University College of Medicine and the University of Cincinnati College of Medicine. He stated that the lectures were well attended at both schools and that it was his opinion this project is increasing in value each year. Mr. Page stated that officials of both schools had given excellent cooperation and support and that the lecturers this year had done an even better job than in the past.

By official action, The Council adopted a resolution expressing appreciation to the Committee on Rural Health which sponsors this project; to its chairman, Dr. Edmond K. Yantes; to Mr. Page for his handling of the details; to the following lecturers, Dr. George A. Woodhouse, Pleasant Hill, Dr. Yantes and Dr. Richard R. Buchanan, Wilmington, Dr. Victor R. Frederick, Urbana, Dr. Robert E. Reiheld, Orrville, Dr. Robert D. Baer, Dalton, and Mr. Edward F. Willenborg, Cincinnati; to Dr. Charles L. Hudson, Cleveland, for his banquet address to the students and their wives, on "The Physician and His Medical Society"; to the officials of the medical schools, particularly Dr. R. L. Meiling and Dr. Chauncey D. Leake, Ohio State University, and the late Dr. Edward McGrath of the University of Cincinnati College of Medicine; and to the Student AMA Chapter, University of Cincinnati College of Medicine.

STATEMENT BY DR. HUDSON

Before The Council recessed for sandwiches and coffee, Doctor Hudson announced that after long and serious consideration he had decided to regard his term as president terminated at the time of the 1956 Annual Meeting in Cleveland, even though the Constitution and By-Laws provide that an officer serving an unexpired term shall not be regarded as having served a full term of office. Doctor Hudson stated that he had served almost one year, having succeeded to the presidency upon the death of Doctor Heusinkveld in June. He said he felt that members of The Council should be aware of his feelings in the matter and he pointed out that this decision on his part would make it necessary for the House

of Delegates at the April meeting to elect a president as well as a president-elect.

REPORTING CHRONIC DISEASES

Following the recess, The Council considered a letter from the Ohio Health Commissioners Conference, reading as follows, and instructed the Executive Secretary to refer it to the Committee on Chronic Illness for study:

"At the recent Ohio Health Commissioners Conference held in September 1955, the Chronic Diseases and Special Programs Committee passed a resolution recommending action be taken relative to the reporting of chronic diseases. The resolution was subsequently adopted by the conference and is as follows:

"1-A It is recommended that the Ohio Department of Health contact the Ohio State Medical Association and the private voluntary health agencies to develop a policy whereby physicians will report chronic disease cases to the local health commissioners. This information will then be made available to voluntary agencies upon their request.

"1-B It is recommended that voluntary health agencies continue their efforts to educate and stimulate physicians to more complete reporting of chronic diseases.

"These recommendations were made in the interest of providing the necessary information needed by official and voluntary health agencies. It was also felt that this will be a means of centralizing this type of information thus making it unnecessary to query each physician when information of this nature is required.

"Therefore, in accordance with the wishes of the Conference, we are directing this to your attention for your consideration."

GROUP MALPRACTICE INSURANCE

A letter from Turner and Shepard, Inc., Columbus, insurance agency, asking the Association to consider the feasibility of organizing group malpractice insurance coverage for all members of the Association, was read and discussed. It was the sense of The Council that no action should be taken until after the AMA has concluded its nationwide, comprehensive study of the malpractice insurance field. By official action, the letter from Turner and Shepard, Inc., was ordered filed for future consideration.

MEDICAL CARE PROGRAM FOR DEPENDENTS OF SERVICEMEN

The Executive Secretary discussed a proposal now pending in Congress to provide medical and hospital care for the dependents of members of the Armed Forces. An analysis of the bill, H. R. 9429, was distributed. It was the opinion of The Council that no action should be taken at this time but that action might be necessary after some legislation is enacted, if it is.

POSTGRADUATE EDUCATIONAL PROGRAM

Letters from the Ohio Hospital Association and the Ohio Academy of General Practice on the same subject were considered. They asked the opinion of the Ohio State Medical Association on a proposal by the Ohio Academy of General Prac-

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New Booklet Presents Latest Facts on Feeding the Sick



Adequate nutrition during illness and convalescence is essential for recovery whether the patient is managed in the hospital or at home. In the latter case, physicians often must devote much time to instructing those responsible for caring for the sick in good nutritional practices.

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tice whereby members of the Academy would be permitted to spend several weeks in a hospital as an observer for the purpose of securing refresher and postgraduate work. By official action, The Council approved the proposal along the same lines as contemplated by the Board of Trustees of the Ohio Hospital Association, namely, that the project be approved, in principle, subject to final action by each hospital and its medical staff:

RATE INCREASE FOR ADVERTISING IN THE OHIO STATE MEDICAL JOURNAL

At the suggestion of the Executive Secretary, The Council considered the possibility of making an advertising rate increase for *The Ohio State Medical Journal* because of increased production costs. After careful consideration, The Council, by official action, authorized a general advertising rate increase for *The Journal* of 15 per cent over the current rates and an increase of \$5.00 per page for color advertising, effective July 1, 1956, so far as new contracts are concerned; January 1, 1957, on T. F. contracts; and effective so far as present advertisers are concerned at the expiration of their current contract.

ADVERTISING BY HOSPITAL CLINIC

Correspondence from the Kentucky State Medical Association, complaining about advertising by an Ohio hospital and clinic in the yellow pages of the telephone directory at Ashland, Kentucky, was read and discussed.

The Executive Secretary read letters he had received from officials of the hospital and clinic. These letters stated that the advertising in the Ashland telephone directory had been ordered discontinued and they expressed sincere regret for having violated the Principles of Medical Ethics unwittingly, promising the situation would not be repeated.

By official action, The Council expressed itself as believing that the letters clarified the situation.

NEWEST DEVELOPMENTS IN CASE OF DR. BOLINGER, MARYSVILLE

The Council was advised that the appeal of Dr. Charles E. Bolinger, Marysville, from the disciplinary action of the Ohio State Medical Association and the Union County Medical Society would be heard by the Judicial Council of the American Medical Association on March 22 in Chicago. The Council authorized Mr. Stichter to attend the hearing as the official representative of the Ohio State Medical Association.

NOMINEES FOR BOARD OF DIRECTORS OF OMI

The President called for a report from the committee named by him to present nominees for the Board of Directors of Ohio Medical Indemnity, Inc., and to be considered at the annual stockholders meeting on April 18.

Dr. Martin reported for the nominating com-

mittee. The committee recommended the re-nomination of the present members of the Board of Directors of Ohio Medical Indemnity, Inc. By official action, The Council approved the recommendation of the committee and it nominated the following for the Board of Directors of OMI: Dr. Robert T. Allison, Jr., Akron; Mr. C. H. Campbell, Columbus; Dr. H. M. Clodfelter, Columbus; Dr. R. Dean Dooley, Dayton; Mr. D. A. Endres, Youngstown; Dr. D. W. English, Lima; Mr. James B. Fenner, Toledo; Mr. Clair E. Fultz, Columbus; Dr. Charles N. Hoyt, Chillicothe; Mr. Edgar W. Jones, Canton; Dr. James S. Mathews, Cincinnati; Mr. Charles Mills, Marysville; Dr. Carll S. Mundy, Toledo; Dr. George H. Sackett, Cleveland; Dr. L. Howard Schriver, Cincinnati; Dr. C. C. Sherburne, Columbus; Mr. Harold W. Slabaugh, Akron; Dr. Robert G. Smith, Circleville; Mr. David L. Temple, Dayton; Dr. Edmond K. Yantes, Wilmington; Dr. Starling C. Yinger, Springfield.

The Council then, on motion duly made, seconded and carried, authorized the following to cast the votes of the Ohio State Medical Association, a stockholder, at the annual stockholders meeting of OMI on April 18, 1956, on all business matters coming before that meeting, including the election of directors placed in nomination by The Council as indicated above: Dr. H. M. Clodfelter, Columbus, or Dr. C. C. Sherburne, Columbus, or Mr. Charles S. Nelson, Columbus.

RESOLUTION FROM SPICER COMPANY LABOR UNION

The Council then considered the following letter from Mr. Frank Szewczykowski, secretary of the Spicer Unit, Local No. 12, UAW, Toledo, and the resolution referred to in the letter:

"Spicer Unit of Local 12, in regular meeting Sunday, February 5, 1956, unanimously passed the attached resolution, which is self explanatory.

"Your utmost cooperation will be greatly appreciated."

"WHEREAS: The program of our Union calls for complete medical, surgical and hospitalization coverage for our members and their dependents, and

"WHEREAS: A major step in this direction was taken with the negotiation of our present collective bargaining agreement which requires Blue Cross-Blue Shield coverage for all Dana employees, and

"WHEREAS: A large percentage of the membership of the UAW has Blue Cross-Blue Shield coverage in their respective collective bargaining agreements, and

"WHEREAS: A large percentage of the doctors and surgeons in this locality will not participate and accept the rates and schedules presently offered by Blue Cross-Blue Shield, and

"WHEREAS: Some of the doctors will accept these rates and schedules, but are not known to our people so they can engage them for services, and

"WHEREAS: The result is that our people are being charged exorbitant rates over and above those allowed by Blue Cross-Blue Shield

causing undue hardship for our members and their families in direct contradiction to the program of our great Union, now,

"THEREFORE BE IT RESOLVED: That Spicer Unit of Local 12 request our International Union to make a study of this problem and see what can be done about relieving this condition and

"BE IT FURTHER RESOLVED: That the officers of our great Union demand a joint meeting with representatives of Blue Cross-Blue Shield and the Ohio and Lucas County, Medical Associations to ascertain if it is possible to arrive at rates and schedules acceptable to all parties concerned so that full coverage and the protection our people require is made a reality, and

"BE IT FINALLY RESOLVED: That copies of this resolution be sent to our Vice-President Richard Gosser, our Regional Director Charles Ballard Local #12, The Toledo Industrial Union Council, the Toledo Hospital Service Association, The Ohio Medical Indemnity, Inc., the Ohio and Lucas County Medical Associations, the International Executive Board and the local press."

By official action, The Council decided that this is a matter which should be investigated by the Toledo Academy of Medicine and instructed the Executive Secretary to submit the matter to the Academy and to advise Mr. Szewczykowski of this action.

Dr. Orr advised The Council that the council of the Toledo Academy of Medicine already has directed a communication to the Union recommending that specific information and details, if available, be submitted to the grievance committee of the Academy for investigation.

AMEF REPORT

Reporting for the Ohio Committee of the American Medical Education Foundation, Mr. Saville stated that the Ohio AMEF total for 1955 was \$30,192.50 from 649 contributors. The 1954 total was \$25,333.50 from 654 contributors, in addition to total gifts of \$71,172.61 made directly by 1,995 Ohio physicians to Alumni Funds of their own medical schools. He said that figures were not yet available on 1955 contributions directly to Alumni Funds, but predicted they would also show a substantial increase over 1954.

MEDICAL EDUCATION WEEK

Mr. Saville advised The Council of plans for the first nationwide observance of Medical Education Week, April 22-28, under the auspices of the American Medical Association, the Association of American Medical Colleges, the National Fund for Medical Education and the American Medical Education Foundation.

REVISION OF FEE SCHEDULE FOR RECIPIENTS OF AID FOR THE AGED

The Executive Secretary advised The Council that the Department of Welfare, Division of Social Administration, wants the assistance of the Ohio State Medical Association in revising the medical fee schedule relating to medical care

for recipients for aid to the aged and other assistance in working out details for the new medical program which will go into effect July 1. By official action of The Council, the President was authorized to appoint a special committee to confer with officials of that department and assist them in every possible way.

MEMORANDUM ON THE POLIO VACCINE SITUATION IN OHIO

For the information of The Council, the Executive Secretary presented each Councilor with a memorandum and certain other material on the polio vaccine situation in Ohio. The memorandum showed that from August, 1955, to March 1, 1956, the State of Ohio had received 981,553 cc. of vaccine; of this amount, 381,839 cc. had been distributed to public agencies (39 per cent), and 599,712 had been made available for commercial distribution (61 per cent). It was pointed out that only about one-third of the necessary amount of vaccine to cover the one to fourteen age group and pregnant women in Ohio had been received up to March 1.

Following reports by Councilors on the activities in their districts, The Council adjourned to meet on Monday evening, April 9, at Hotel Statler, Cleveland.

Attest: CHARLES S. NELSON,
Executive Secretary.

Fort Steuben Academy Holds Meetings

Subject of discussion at the January 10 meeting of the Fort Steuben Academy of Medicine was "Surgical and Medical Aspects of Biliary Diseases." Discussants were Dr. Samuel Harbison, Department of Surgery, University of Pittsburgh; Dr. Lucien Gregg, Department of Medicine, University of Pittsburgh, and Dr. Albert E. Winston, Steubenville. The program followed dinner at the Fort Steuben Hotel, Steubenville.

Dr. William F. Rienhoff, Jr., Department of Surgery, Johns Hopkins University, Baltimore, was guest speaker on the program with Dr. John L. Quinn, of Steubenville, for the March 13 meeting.

Kentucky Association Has New Secretary-Editor

Bruce Underwood, M.D., secretary and general manager of the Kentucky State Medical Association and editor of the Journal, resigned as of February 1 to take a position with the Department of Health Education and Welfare in Washington.

Woodford B. Troutman, M.D., Louisville, was elected by the Council of the Kentucky State Medical Association as secretary-editor pro-tem. He assumed this office on February 1.

Ohio Mental Hospitals Will Release Numerous Elderly Patients for Protective Care in Homes

The Ohio Department of Mental Hygiene and Correction has announced a plan whereby it will release many elderly persons from mental institutions and help adjust them to custodial care in boarding homes, rest homes, county homes or in the homes of relatives or friends.

Studies are now under way to determine how many persons in the over 65 age group can thus be released. Present indications are that there will be between 5,000 and 6,000 in first group who need only protective care but are sane. A corresponding number of beds will thus be released in mental hospitals for the mentally ill, Dr. John D. Porterfield, director of the Department, said.

Such a procedure is not new to the Department, since a limited number of persons principally in other age groups have been released under a similar program. Dr. Porterfield said, however, that financial considerations have been the major stumbling block in the formation of such a plan for elderly patients on a large scale.

The Social Service Section of the Department of Mental Hygiene will supervise the program during a trial period of about nine months for each patient placed. Patients from each mental hospital will be under direction of psychiatric social workers attached to that hospital.

Eventually, as each person adapts to the custodial care, he will be placed under the supervision of the Aid for the Aged program. Financial assistance will be available from Aid for the Aged funds, Social Security, Veterans Administration, aid to the total and permanently disabled, local welfare funds, and other assistance agencies for aged persons. Private income of the individual or assistance from the family will be utilized where available.

Under the first priority of elderly persons to be released will be those who are not disturbing, who can wash and dress themselves, present themselves for meals, and the like. A requisite for the custodial home will include some provision for recreation and assurance that the individual will have some provision for occupying his time.

For the trial period social welfare workers will visit the patient to determine that he is getting along satisfactorily. It is planned that a worker will spend at least one full day a month with the patient. Any persons who do not adjust to the protective care program will be returned to the hospital.

Medical care will be provided by the hospital during the initial period and patients who need hospitalization will be returned to the hospital. Provisions will be made for emergency medical care at all times.

COMING MEETINGS

Ohio State Medical Association, Annual Meeting, Cleveland, April 10-12.

Aero Medical Association, Drake Hotel, Chicago, April 16 - 18.

American College of Allergists, Inc., Twelfth Congress, Hotel New Yorker, New York, April 15 - 20.

American College of Chest Physicians, 22nd Annual Meeting, Hotel Sherman, Chicago, June 6 - 10

American Medical Association, Annual Session, Chicago, June 12-14.

American Congress of Physical Medicine, 34th Annual Session, Atlantic City, September 9-14.

American Goiter Association, Annual Meeting, Drake Hotel, Chicago, May 3-5.

American Association of Blood Banks, September 3-5, Somerset Hotel, Boston, Mass.

Association of American Physicians and Surgeons, Annual Meeting, Deshler-Hilton Hotel, Columbus, April 5-7.

Cancer Conference, Third National, American Cancer Society and National Cancer Institute, Detroit, Mich., June 4-6.

Cleveland Society of Obstetrics and Gynecology, Cleveland University Club, April 9, an invitational meeting for Ohio specialists in field.

1956 Industrial Health Conference, Convention Hall, Philadelphia, Pa., April 21-27.

International Academy of Proctology, Eighth Annual Convention, Drake Hotel, Chicago, April 23 - 26.

International College of Surgeons, Regional Meeting of the American Section, Madison, Wisc., April 26-28.

National Tuberculosis Association, 52nd Annual Meeting, New York City, May 21 - 23; also 51st Annual Meeting of the American Trudeau Society.

Ohio State Heart Association, Annual Meeting, Cleveland, April 9.

Ohio State Radiological Society, Convention, Deshler-Hilton Hotel, Columbus, May 11-13.

Veterans Administration, Series of Wednesday evening Clinical Conferences, Cuyahoga Bldg., Cleveland, through May 23.

West Virginia Chapter, American Academy of General Practice, Scientific Assembly, Daniel Boone Hotel, Charleston, April 14-15.

Pair Involved in Medical Diploma Mill Convicted in Cleveland Court

Following their conviction by a jury for selling worthless medical diplomas, two men were sentenced to from one to three years in the Ohio Penitentiary by Judge Donald F. Lybarger of the Cuyahoga Common Pleas Court.

They are Edward M. B. Ownen and Robert J. Broadwell who in 1953 attempted to set up a "medical diploma mill" in Cleveland. According to testimony the pair solicited and sold worthless diplomas to unlicensed chiropractors, other limited practitioners and immigrant practitioners, with a promise to help them obtain Ohio licenses.

The case was prosecuted by the Cleveland Better Business Bureau with the aid of the State Medical Board. Dr. H. M. Platter, secretary, and Lawrence Dietrich, inspector for the State Medical Board, took an active part in the case in behalf of the prosecution.

Ownen came to Ohio from Missouri where he operated an unrecognized school for limited practitioners and represented himself as a naturopath, a branch not recognized in Missouri. He was wanted by Missouri authorities. Broadwell formerly was a technician in an osteopathic hospital in Cleveland.

Attorneys for both men announced their intention to appeal.

Some Population Figures for the Nation and for Ohio

An increase of 2,810,000 during 1955 brought the population of the United States to 166,740,000 at the year's end, the Metropolitan Life Insurance Company's statisticians estimated. The increase was only 13,000 less than the all-time record set in 1954.

Ohio experienced a population growth well above the national average, according to the national statisticians. William H. Veigel, chief of the Division of Vital Statistics, Ohio Department of Health, estimated that Ohio births for 1955 will amount to 221,550 and that deaths will number 82,825, or a natural population increase in Ohio of 138,728. Exact figures cannot be given until all birth and death certificates are in the hands of the Division.

The past year was the tenth in which the high rate of population growth continued unabated. During the decade the gain was about 26,000,000 for the nation, a larger number than in the preceding 21 years.

According to the *Ohio General Practice News*, the membership of the Ohio Academy of General Practice on February 1, 1956, was 1,436 and the membership of the American Academy of General Practice, 20,653.

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Higher, Faster Blood Levels than Twice
the Dose of Injected Procaine Penicillin*



This ready-mixed, stable, and pleasantly flavored suspension is supplied as follows: PEN•VEE•Suspension, 300,000 units per 5-cc. teaspoonful, bottles of 2 fl. oz. Also available: PEN•VEE•Oral Tablets, 200,000 units, scored, bottles of 36; 500,000 units, scored, bottles of 12.

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These Ohio Pathologists Offer Cytology Diagnostic Service

Some time ago *The Journal* warned physicians against a cancer detection plan which offered cytology tests for their patients at certain laboratories located in different parts of the country. One of several reasons cited against such projects was that such tests are available in many areas of Ohio and that use of local facilities would be more desirable for everyone concerned.

Shortly thereafter, *The Journal* asked the Ohio Society of Pathologists to furnish a list of Ohio pathologists offering cytology diagnostic service. The society polled its members, asking those who offer such service and who wanted their name listed, to so indicate. As a result the following list of members of the Ohio Society of Pathologists who offer cytology diagnostic service was compiled. It is being published for the information of physicians who may have reason to want such service for certain patients:

AKRON

Proskauer, Geo. G., St. Thomas Hospital

ASHTABULA

Dixon, J. Jason, Ashtabula General Hospital

CANTON

Shaweker, Max, Mercy Hospital

Henderson, Donald, Aultman Hospital

CINCINNATI

Landing, B. H., Children's Hospital

CLEVELAND

Bayless, Francis, 10300 Carnegie Ave.

Dominquez, Rafael, St. Luke's Hospital

Gold, Harold, Mount Sinai Hospital

Goodsitt, Edward, Huron Road Hospital

Hazard, John B., 2050 E. 93rd St.

Hirsch, Victor S., 10300 Carnegie Ave.

Kinney, Thomas D., Cleveland City Hospital

Mackrell, Jr., John S., St. Vincent Charity Hosp.

McCormack, L. J., Cleveland Clinic

Reagan, James W., 2085 Adelbert Road

Siegler, Edw., St. Luke's Hospital

Sinclair, Jr., William, 2609 Franklin

Tillotson, Frederick W., 10300 Carnegie Ave.

COLUMBUS

Bubis, Sylvia, Grant Hospital

Davidson, Horace B., 267 E. Broad St.

Johansmann, Ralph J., White Cross Hospital

Reinhart, Harry L., University Hospital

DAYTON

Abramson, William, 1080 Reibold Bldg.

Dille, Charles A., 393 West First Street

EAST LIVERPOOL

Costello, R. C., 405 Little Bldg.

ELYRIA

Thomas, R. G., Elyria Memorial Hospital

HAMILTON

Lande, K. E., Mercy Hospital

LAKEWOOD

Eitzen, Oliver, Lakewood Hospital

LIMA

Blumstein, Charles L., St. Rita's Hospital

Hughes, Donald E., St. Rita's Hospital

MANSFIELD

Harsh, Robert C., Mansfield General Hospital

Hathaway, Burr M., Mansfield General Hospital

MARIETTA

Thornburgh, D. B., Marietta Memorial Hospital

MASSILLON

Kerr, S. E., Massillon City Hospital

MIDDLETOWN

Williams, Robert R., Middletown Hospital

PORTSMOUTH

Gohmann, Joseph T., Mercy Hospital

SALEM

Falkenstein, A. P., 1234 Cleveland Street

SPRINGFIELD

Hunter, Mary P., Mercy Hospital

Wybel, Robert E., Springfield City Hospital

TOLEDO

Hartung, Jr., W. H., St. Charles Hospital

Rhoden, A. E., 2360 Monroe St.

Snively, J. C., Maumee Valley Hospital

Steinberg, Bernhard, Toledo Hospital

Van Baaren, H. J., 3349 Cherry Street

WOOSTER

Redfield, Ernest S., Wooster Community Hospital

ZANESVILLE

Smith, William B., Good Samaritan Hospital and Bethesda Hospital.

Dr. Ristine Named Acting Mental Hygiene Commissioner

Dr. Leonard P. Ristine has been formally appointed acting commissioner of the State Division of Mental Hygiene. The appointment was made by Dr. John D. Porterfield, director of the Department of Mental Hygiene and Correction, with the concurrence of the advisory council to the Division of Mental Hygiene.

Dr. Ristine, an assistant commissioner for the past year, has been directing the work of the Division since the resignation of the commissioner last summer.

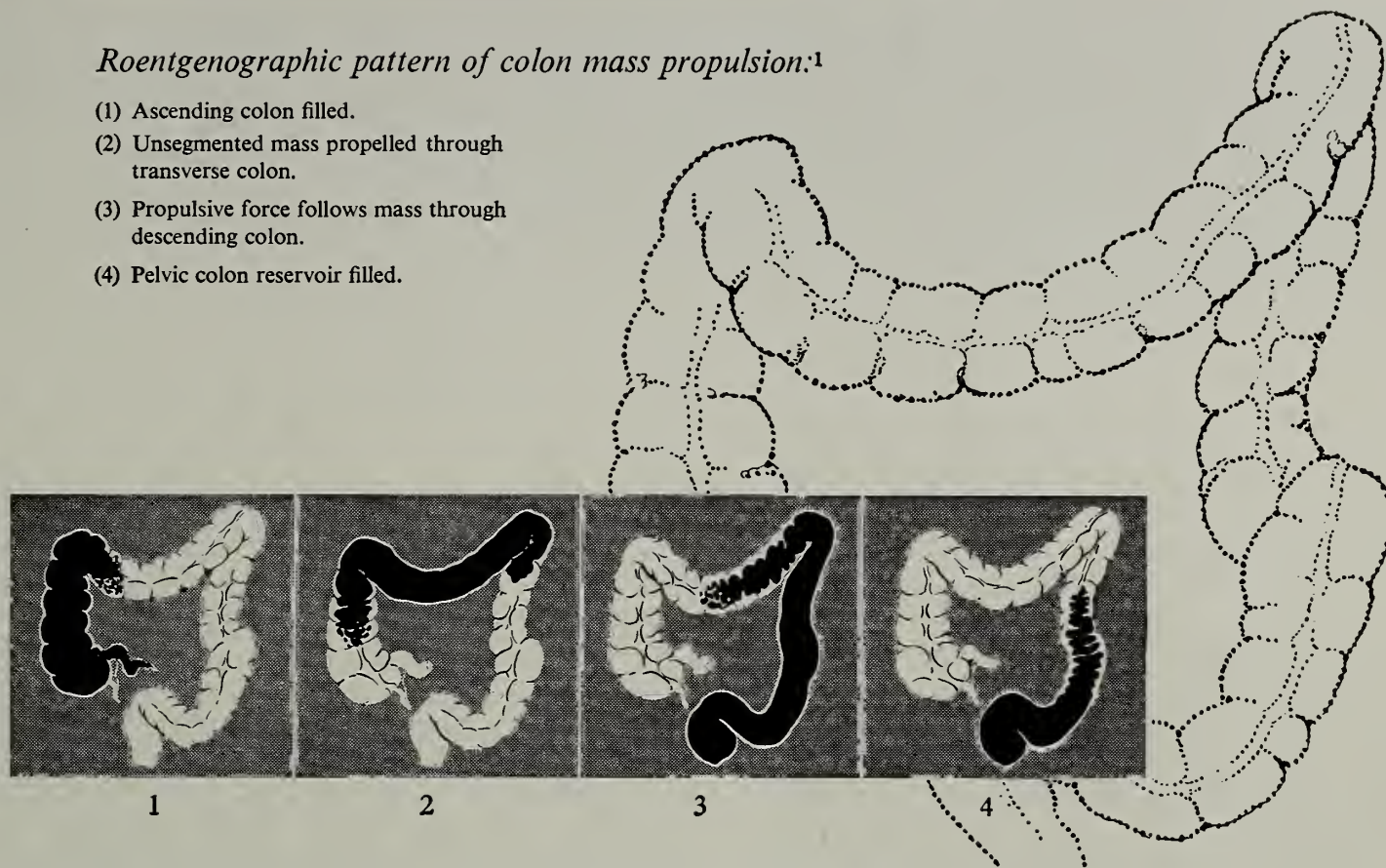
Akron Abortionist Sentenced

Dr. Roy L. Knapp, 72-year-old Akron physician, admitted abortionist, has been sentenced to four months in the county jail, placed on probation for five years and ordered by the court to discontinue the practice of medicine. Knapp has been cited to appear before the State Medical Board which is contemplating revocation of his license. During the trial, he confessed that he had been performing abortions since 1934 at the rate of approximately 300 a year at an average fee of \$200. The court did not sentence Knapp to the penitentiary because of his age and physical condition.

SMOOTHAGE ACTION IN CONSTIPATION

*Roentgenographic pattern of colon mass propulsion:*¹

- (1) Ascending colon filled.
- (2) Unsegmented mass propelled through transverse colon.
- (3) Propulsive force follows mass through descending colon.
- (4) Pelvic colon reservoir filled.



Reestablishing Bowel Reflexes with Metamucil®

*Nervous fatigue, tension, injudicious diet, failure to establish regularity, too little exercise, excessive use of cathartics—all factors which contribute to constipation.*²

Sufficient bulk and sufficient fluid form the basic rationale of treatment of constipation. Metamucil (the mucilloid of *Plantago ovata*) produces a bland, smooth bulk when mixed with the intestinal contents. This bulk, through its mass alone, stimulates the peristaltic reflex and thus initiates the desire to evacuate, even in patients in whom postoperative hesitancy exists.

Correction of constipation logically, therefore, lies in the suitable adjustment of such factors as nervous fatigue and tension, improper intake of fluid, improper dietary habits, failure to respond to the call to stool, lack of physical exercise and abuse of the intestinal tract through excessive use of laxatives.²

The characteristics of Metamucil permit the correction of most of these factors: it provides bulk; it demands adequate intake of fluids (one glass with Metamucil powder, one glass after each dose); it increases the physiologic demand to evacuate; and

it does not establish a laxative "habit." Metamucil, in addition, is inert, and also nonirritating and non-allergenic.

The average adult dose is one rounded teaspoonful of Metamucil powder in a glass of cool water, milk or fruit juice, followed by an additional glass of fluid if indicated.

Metamucil is the highly refined mucilloid of *Plantago ovata* (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent. It is supplied in containers of one pound—also four ounces and eight ounces. G. D. Searle & Co., Research in the Service of Medicine.

1. Best, C. H., and Taylor, N.B.: *The Physiological Basis of Medical Practice: A Text in Applied Physiology*, ed. 5, Baltimore, The Williams & Wilkins Company, 1950, pp. 579-583.

2. Bargen, J. A.: A Method of Improving Function of the Bowel, *Gastroenterology* 13:275 (Oct.) 1949.

SEARLE

County Society Officers Meet . . .

More Than Two-Thirds of Local Medical Societies Are Represented As Group Gets Together in Columbus with State Association Officers

SIXTY County Medical Societies were represented at the Annual Conference of County Medical Society Officers, sponsored by the Ohio State Medical Association, at the Neil House, Columbus, on Sunday, February 12. The total attendance was 160, including presidents and secretaries of County Medical Societies, chairmen of legislative and public relations committees, and officers and certain committeemen of the State Association. For the past two years these conferences had been held in conjunction with the Annual Meeting, but The Council this year decided to revert to the former policy of having a separate and distinct meeting, earlier in the year than the Annual Meeting.

Dr. Charles L. Hudson, Cleveland, President of the Association, presided at the meeting and explained the purpose of the conference. He emphasized the important role county medical society officers play in the medical organization echelons—local, state or national.

The responsibility of local society officers in regard to legislative matters and legal responsibility within the organization constituted an important part of the conference. The importance placed on this phase was emphasized by the fact that four attorneys were present to take part in the program.

LEGISLATIVE AND LEGAL MATTERS

R. G. Van Buskirk, executive secretary of the AMA's Committee on Legislation, informed the group on the status of medical-health bills pending before Congress. He emphasized the important role local physicians can play in contacting their representatives and making known their views on pending legislation."

C. Joseph Stetler, director of the AMA's Legal Department, discussed "The Malpractice Problem."

Another important feature of the meeting was a panel discussion on medico-legal problems. Charles S. Nelson, Executive Secretary of the Association, was moderator of the panel. Taking part were Mr. Stetler; Mr. Van Buskirk; Mr. Wayne E. Stichter, Toledo, legal counsel for the OSMA; Mr. Edward F. Willenborg, Executive Secretary of the Academy of Medicine of Cincinnati and an attorney; and Dr. George A. Woodhouse, Pleasant Hill, a member of the Judicial Council of the AMA.

COOPERATION WITH HEALTH AGENCIES

Dr. Ralph E. Dwork, director of the Ohio Department of Health stressed the need for con-

tinuing cooperation between local health commissioners and county medical societies, in a talk entitled, "Ohio's Public Health Program—Our Joint Responsibility."

A series of short talks suggesting projects to increase interest in local organization work were given.

The first of these talks, entitled "How To Get 'Em Out to Meetings," was presented by Dr. George A. Sudimack, Warren, immediate past-president of the Trumbull County Medical Society. He described the successful plan being worked in that county.

Hart Page, assistant director of the Association's Department of Public Relations, gave a brief summary of the many exhibits, movies, pamphlets, and the like available through the Columbus Headquarters Office.

The importance of having the local medical society represented by reports in *The Ohio State Medical Journal* was stressed by Gordon Moore, news editor.

George H. Saville, public relations director for the Association, emphasized the important role of the legislative committee and the necessity of having local physicians show an interest in candidates for public office and political issues during an election year.

Each Councilor had an opportunity to meet with persons from his District. Approximately 45 minutes were given for this purpose when the conference split up into District meetings where opportunity was given for discussion of local problems.

The finale of the meeting was a question and answer period under direction of Dr. Hudson. The numerous questions presented in this period showed the interests brought to the light by the various discussions.

THOSE ATTENDING

Those registered at the conference included the following:

OFFICERS AND COUNCILORS: Charles L. Hudson, Cleveland, President; Merrill D. Prugh, Dayton, Past-President; First District Councilor, C. T. Atkinson, Middletown; Second District, G. A. Woodhouse, Pleasant Hill; Third District, James R. Jarvis, Van Wert; Fourth District, Paul F. Orr, Perrysburg; Fifth District, George W. Petznick, Shaker Heights; Sixth District, C. A. Gustafson, Youngstown; Seventh District, R. E. Hopkins, Coshocton; Ninth District, C. L. Pitcher, Portsmouth; Tenth District, Edwin H. Artman,



Sixty of Ohio's County Medical Societies were represented as presidents, secretaries and other key persons of local organizations got together with officers of the State Association in Columbus on February 12.

Chillicothe; and Eleventh District, H. T. Pease, Wadsworth.

FIRST DISTRICT: Adams County—Hazel L. Sproull, West Union; Butler County—D. M. Blizard and Thomas Wenzel, Middletown; Clermont County—Carl A. Minning, Batavia; A. G. Schulze, Amelia; Clinton County—A. F. Lippert, Wilmington; Hamilton County—J. R. Hudson, Elmer R. Maurer, Charles A. Sebastian, and Mr. Edward F. Willenborg, all of Cincinnati; Highland County—J. Martin Byers, Greenfield; Clifford G. Foor, Hillsboro; Warren County—J. A. Browning, S. J. Shapiro, George A. Sudimack, all of Warren; D. Paul Ward, Pleasant Plain.

SECOND DISTRICT: Clark County—Frank Anzinger, Jr., Edwin Ash, Mr. C. W. Edgar, John D. LeFevre, and Charles J. Townsend, all of Springfield; Darke County—Westbrook Browne, Maurice Kane, and Robert C. Prophater, all of Greenville; Greene County—P. D. Espey, Robert D. Hendrickson, and R. David Warner, all of Xenia; Miami County—E. R. Irvin, Bradford; Dale A. Hudson, W. W. Trostel, and W. T. Wilkins, Jr., all of Piqua; Montgomery County—R. Dean Dooley, Mr. R. F. Freeman, Mason S. Jones and Ward McCally, all of Dayton.

THIRD DISTRICT: Allen County—T. D. Allison, Fred P. Berlin, F. A. Hemsath, and David L. Steiner, all of Lima; Auglaize County—W. V. Barton and Dale L. Kile, St. Marys; Crawford County—K. H. Barth, New Washington; Hobart L. Mikesell, West Liberty; Hancock County—Howard Evans, Findlay; Hardin County—Floyd M. Elliott, Ada; Marion County—M. F. Axthelm, Caledonia; Frank C. Vogt, Marion; Wyandot County—Herschel A. Rhodes and C. B. Schoolfield, Upper Sandusky.

FOURTH DISTRICT: Henry County—Thomas F. Tabler, Holgate; Ottawa County—Cyrus R. Wood, Port Clinton; Putnam County—James B. Overmier, Leipsic; Wood County—H. W. Mannhardt, Bowling Green, J. V. Pilliod, Grand Rapids.

FIFTH DISTRICT: Ashtabula County—William J. McCarthy, Ashtabula; Cuyahoga County—John H. Budd, Mr. M. John Hanni, Macon Leigh, and Howard P. Taylor, all of Cleveland; Geauga County—W. C. Corey, Chardon; Lake County—John W. Davis, Painesville.

SIXTH DISTRICT: Columbiana County—R. Osmundsen, Salem; J. Keith Rugh, East Liverpool; Mahoning County—G. E. DeCicco, Youngstown; Portage County—David S. Palmstrom and R. E. Roy, Ravenna; Stark County—Mr. E. M. Sprunger and R. E. Tschantz, Canton; G. M. Wilcoxon, Alliance; Summit County—A. F. Dornier and Carl C. Nohe, Akron; Trumbull County—G. A. Sudimack, Warren.

SEVENTH DISTRICT: Belmont County—D. Danenberg, Bridgeport; B. C. Diefenbach, Martins Ferry; Carroll County—Carl A. Lincke, Carrollton; Joseph D. Stires, Malvern; Coshocton County—Robert R. Johnson and H. W. Lear, Coshocton; Harrison County—G. E. Henderson, New Athens; Jefferson County—John P. Smarrella, Steubenville; Warren G. Snyder, Wintersville; Tuscarawas County—C. R. Crawley, J. W. Hamilton, H. E. Reed, Dover; Jay W. Calhoon, Uhrichsville; Paul D. Hahn, New Philadelphia.

EIGHTH DISTRICT: Fairfield County—W. D. Monger, Chester P. Swett, Arthur B. Van Gundy, all of Lancaster; Guernsey County—Thomas W. Frame, Byesville; Licking County—Louis J. Tilton, Frazeyburg; Muskingum County—Fred W. Phillips, Zanesville.

NINTH DISTRICT: Jackson County—B. J. Allison, Oak Hill; J. L. Frazer, Wellston; Lawrence County—V. W. Blagg, Harry Nenni, and George Newton Spears, all of Ironton; Scioto County—Clyde M. Fitch and B. U. Howland, Portsmouth.

TENTH DISTRICT: Delaware County—Donald L. Gantt and Tennyson Williams, Delaware; Franklin County—Ralph E. Dwork, E. W. Harris, Robert M. Inglis, Mr. Stanley R. Mauck, Wilson P. Shortridge and Mr. William Webb, Jr.,

all of Columbus; J. L. Henry, Grove City; **Knox County**—James C. McLarnan, Mt. Vernon; **Madison County**—Sol Maggied, West Jefferson; **Pickaway County**—Walter F. Heine, E. L. Montgomery and Robert G. Smith, all of Circleville; **Ross County**—Lewis W. Coppel, C. N. Hoyt, Ralph W. Holmes, Robert E. Quinn, M. D. Scholl and Robert E. Swank, all of Chillicothe; **Union County**—B. E. Ingmire, Plain City.

ELEVENTH DISTRICT: **Erie County**—A. R. Grierson, Arthur G. Groscost, S. R. Hoover, H. F. Kesinger and E. J. Meckstroth, all of Sandusky; **Holmes County**—Luther W. High and Owen F. Patterson, Millersburg; **Huron County**—William W. Corwin and John V. Emery, Willard; **Lorain County**—Paul J. Kopsch and Thomas L. Smith, Lorain; G. R. Wiseman, Amherst; **Medina County**—R. W. Avery, Seville; W. G. Halley, Lodi; N. J. M. Klotz, Wadsworth; R. L. Mansell, Medina; C. F. Schrier, Litchfield; **Richland County**—C. F. Curtiss, Bellville; Edward D. Conner, Riley E. Frush and P. O. Staker, all of Mansfield.

OTHERS: Mr. Wayne E. Stichter, Toledo, Legal Counsel for OSMA; Mr. C. Joseph Stetler, Chicago, director of the AMA's Legal Department; Mr. R. G. Van Buskirk, Chicago, Executive Secretary of the AMA's Committee on Legislation; Mr. W. H. Veigel, chief of the Division of Vital Statistics, Ohio Department of Health; and Messrs. Nelson, Saville, Page and Moore, of the OSMA executive staff.

One-Man Hospital Receives Joint Commission Accreditation

Every year the Joint Commission on Accreditation of Hospitals surveys 1,500 hospitals, and over a three-year period it surveys 4,000 institutions. Not until recently has it ever approved a hospital directed and operated by only one physician.

The Maynard MacDougall Memorial Hospital in Nome, Alaska, a 25-bed institution, was given full accreditation by the Joint Commission recently. The hospital is run by the Women's Division of Christian Service of the Board of Missions of the Methodist Church and its medical director and only physician on the staff is Dr. Fred M. Langsan, a general practitioner.

Dr. Langsan often holds consultations with members of a U. S. Air Force hospital which is located nearby. Staff people of the Air Force hospital have flown into Nome to be of assistance at specific times. All x-rays and pathological tissues are sent to Seattle and the reports are sent back air mail.

Commenting on the fact that this is the first one-man hospital ever accredited by the commission, Dr. Babcock said "It's a wonderful example of a fine job being done by a dedicated general practitioner."

New Members of O. S. M. A.

The following are the names of the new members of the Ohio State Medical Association since February 1st, 1956. The list shows the county in which they are affiliated, city in which they are practicing, or temporary address in cases where physicians are taking postgraduate work.

ATHENS COUNTY

Wolfard Baumgartel,
Albany
Roary A. Murchison,
Athens

CARROLL COUNTY

John R. Tarr, Minerva

COLUMBIANA COUNTY

Jeko M. Nedelkoff,
Salineville
Ernest P. Schaefer, Salem

CRAWFORD COUNTY

Raymond N. Stephens,
Galion

CUYAHOGA COUNTY

Jankiel Barg,
Garfield Hts.
J. Wallace Blunt,
Cleveland
Frank A. Costanzo,
Fairview Park
Edward N. Hinko,
Cleveland
Daniel C. Maras,
Cleveland
Antonio L. Pesce,
Cleveland
Margret Pribram,
Cleveland
Jeurgan L. Schapiro,
Cleveland
Kurt W. Seiffert,
Cleveland
Simon Spendiarian,
Cleveland
Lloyd U. Young,
Cleveland

DARKE COUNTY

James H. Dickey,
Greenville

DELAWARE COUNTY

Irene Lazdins, Delaware

FRANKLIN COUNTY

Frank H. Herrington,
Columbus
Robert B. Larrick,
Columbus
Justus F. C. Lehmann,
Columbus
Vol K. Philips, Columbus
Juddson E. Shephard,
Columbus

GALLIA COUNTY

Norman Goldstein,
Gallipolis

HAMILTON COUNTY

Fritz W. Albiez,
Cincinnati
John H. Arce, Cincinnati
Irwin L. Berstein,
Cincinnati
John H. Bechtel,
Cincinnati

William C. Carpenter,
Cincinnati
Chatham G. Clements,
Cincinnati
Milton M. Goldfarb,
Cincinnati
Robert H. Hume,
Cincinnati
Gottfried Krupnik,
Cincinnati
Robert A. Matuska,
Cincinnati
Geo. T. Mellinger,
Cincinnati
D. Bruce Nicholson,
Cincinnati
Lucy O. Oxley,
Cincinnati
Morris Plotnick,
Cincinnati
Walter B. Rugh, Jr.,
Cincinnati
James L. Titchener,
Cincinnati

JEFFERSON COUNTY

Andrew Maciurak,
Bergholz

LORAIN COUNTY

Stase Kerpe, Elyria

LUCAS COUNTY

Leon L. Allen, Toledo
Harry B. Friedgood,
Rossford
Paul E. Geiger, Toledo
John H. Gross, Toledo
Jerome Kimmelman, Toledo
Richard L. Schafer, Toledo
Daniel G. Tanner, Toledo
Burchard Winne, Toledo

MAHONING COUNTY

Leonard P. Caccamo,
Youngstown

MARION COUNTY

Henry C. Blount, Marion

MONTGOMERY COUNTY

Harold D. Robertson,
Dayton

PORTAGE COUNTY

Anthony F. Lalli, Hiram

RICHLAND COUNTY

Marvin F. Dees, Mansfield

SANDUSKY COUNTY

John J. Gedert, Jr., Clyde

STARK COUNTY

Stoyan P. Daskalov,
Alliance
Marion M. Estes, Canton
Fred Kauffmann, Canton
D. E. Leavenworth, Canton

SUMMIT COUNTY

Harold E. May, Akron

Cincinnati—Dr. Bernard Wexler, research associate of the May Institute for Medical Research of the Jewish Hospital Association, was awarded the Wm. S. Merrell Company research scholarship in gerontology.

Jefferson—Dr. H. K. Lynne was named "Man of the Year" by the Jefferson Business Council.

Health Exam Project . . .

General Electric Co. Program for Employees Reviewed by Committee On Public Relations and Economics; Policy Drafted and Approved

FOLLOWING is a report of actions taken and recommendations made by the Committee on Public Relations and Economics of the Ohio State Medical Association at a meeting on January 15, 1956. The report was submitted to The Council of the Association on March 11 and officially approved by The Council. (See Page 402.)

* * *

A meeting of the Committee on Public Relations and Economics was held in the Columbus Office on Sunday, January 15.

Present by invitation were: Richard J. Eales, Health Insurance Council, New York; E. O. Smith, Chief Claim Adjuster, Travelers Insurance Company, Columbus; Dr. Charles A. Sebastian, President, and Edward F. Willenborg, Executive Secretary, Cincinnati Academy of Medicine; Dr. Logan T. Robertson, Director, Occupational Health Service, Asheville, N. C.; Dr. E. M. Kline, Medical Director, Lamp Division, General Electric Company, Cleveland; Dr. E. R. McNeal, Medical Director, Lamp Division, General Electric Company, Youngstown; Dr. Stephen W. Ondash, member of the Council of the Mahoning County Medical Society and Dr. H. P. McGregor, Past-President, Mahoning County Academy of General Practice.

QUESTION OF INSURANCE FORMS

The committee reviewed the conclusions which it had reached at its meeting on October 2 on the question of standardized insurance report forms.

Supplementing a memorandum which he had prepared for members of the committee prior to the meeting, Mr. Eales expressed the hope that the committee would accept the forms which had been developed by the Health Insurance Council and approved by the American Medical Association after several years' consideration. He stated that the forms devised by local medical societies in Ohio were not satisfactory in that they did not supply sufficient information; that their use would result in extra correspondence in order to obtain information necessary for the settlement of claims.

Mr. Willenborg pointed out that many of the questions on the H. I. C. forms were for the purpose of comparison by the insurance company's investigator with statements made by the claimant, and that it was not the responsibility of the attending physician to prove that information furnished by the claimant was false. He also stated that most insurance companies writing business in the Cincinnati area are accepting the

standardized form adopted by the Cincinnati Academy of Medicine.

Following a lengthy discussion, the Committee voted to ask the Chairman to appoint a subcommittee to draft a simplified form for its consideration. It was the consensus that this form could be based on the Cincinnati form with a few additional items.

G. E. HEALTH EXAM PROJECT

The Committee then considered the medical examination program offered to industry by the Occupational Health Service. Dr. Logan T. Robertson, originator and director of the Service, explained that the physical examination service was offered to company employees on a voluntary basis, at the expense of the employer, the examination being done in trailers furnished by Occupational Health Service, which also supplies the non-medical staff. Local physicians are employed on a per diem basis for the examinations. He also stated that it was the policy of the Service to contact local medical society officers to advise them of the program. Dr. Robertson said the results of the examination are confidential; that they are not divulged to the company, but are transmitted by letter to the employee and to his family physician.

Dr. Kline described the program as being a demonstration of management's interest in the health of its employees; that it was really a health education program. He said that management belongs in preventive medicine but does not want to get into treatment.

Dr. McNeal said that after investigating the program he was convinced that it had merit; that before starting it in Youngstown he had discussed it with the President and President-Elect of the Mahoning County Medical Society.

Opposition to the program was expressed by Dr. Ondash, representing the Council of the Mahoning County Medical Society, and Dr. McGregor in behalf of the Mahoning County Academy of General Practice. Dr. Ondash was chairman of a committee of the Mahoning County Medical Society which made a study and report on Occupational Health Service, the report being approved by the Council of the Society and copies furnished to the State Association's Committee on Public Relations and Economics.

OBJECTIONS PRESENTED

Their principal objections were:

1. The program was instituted in Youngstown without an official approach to the county

medical society and before the opinion of the entire membership could be ascertained.

2. Such surveys are in direct violation of the patient-doctor relationship, the basis on which the best medical service is built.

3. The examinations on a mass basis—of the screening variety—without adequate history taking, lack the fundamental requisites for real evaluation.

4. There is danger that such surveys will become involved in industry-labor bargaining negotiations, even including the addition of therapeutic services—all to the economic detriment of the individual practitioner.

5. The insistence that specialists be used in the panel for examinations is a reflection on the caliber of medical care in the community and mitigates against the generally accepted opinion that the doctor's office is the primary source of disease detection.

6. Such surveys arranged for by hired consultants with the utilization of mobile equipment and salaried professional and non-professional aides, constitute the corporate practice of medicine.

7. The extent of management must be: (a) the physical examination requisite for employment and repeated examination as indicated to job requirement; (b) the provision of in-service for emergency medical care; (c) the provision of insurance for medical services as a fringe benefit. Any further expansion of employee interest must be done only if the employee's basic freedoms are preserved and he is made well aware of the ultimate cost to him.

DETAILED TESTIMONY

Dr. Ondash said that the Mahoning County Medical Society is prepared to meet with any industry desiring to expand its relationships on the basis of providing a medical service embodied in a periodic health service to its employees; that it is prepared to discuss and recommend any plan which will first carry out the fundamental essence of any such examination, namely the patient-doctor relationship and its sanctity; and that it will offer a superior service at a reasonable rate and will unhesitatingly approve wholesome participation of any of its membership if they work in concert to such agreement and thereby enhance medical service to the community in the voluntary way.

In discussing further what they considered benefits of the program, Drs. Robertson, Kline and McNeal pointed out that a total of 1,656 employees (543 male, and 1113 female) were examined at the four General Electric Lamp Division plants, an average participation of 87 per cent of the total number of employees in these plants. While the greater percentage were classified as normal or with minor defects, 20 per cent were found to have medical conditions considered to be serious or potentially serious.

They also stated that it was their wish to work in accord with the wishes of the local medical societies, and further that the physicians selected to conduct the examinations need not be specialists.

Dr. Ondash stated that the Industrial Health Committee of the Mahoning County Medical Society is studying the matter of health surveys, including the provision of a periodic health examination or survey which would be acceptable to its members when the society is approached by an industry considering an extension of medical service to its employees. Dr. Ondash was of the opinion that the matter could be resolved through consultation with the local medical society.

OFFICIAL STATEMENT OF POLICY

After a general discussion, the committee adopted the following statement of policy: (Note: Officially approved by The Council)

"The committee commends the interest which the General Electric Company has in the health of its employees. In fact, it sees nothing objectionable in the program of the General Electric Company for extending to all of its employees any benefits which may accrue from periodic health examinations, which it has heretofore made available to its executives, or in the willingness of the General Electric Company to pay for these examinations.

"The committee is convinced that the best long-term furtherance of the health of these employees will be served if the usual doctor-patient relationship is maintained and furthered. It recognizes, however, that it may not be possible to procure the examinations or tabulate the results on this basis; therefore, it is felt that where it is not possible to arrange for examinations within the scope of the normal doctor-patient relationship that the type of examination offered by Occupational Health Service could be approved.

"Experience has proven, however, that it is desirable to discuss the various types of examinations and the possible arrangements for them with the proper representatives of the local County Medical Society before any plan of action is decided upon, in order that a mutually satisfactory arrangement may be achieved.

"The committee feels that it is incumbent upon the representative of the General Electric Company and Dr. Logan Robertson of Occupational Health Service to recognize that approval of this present project by the local medical society is limited; that any expansion or repetition of this program should, in each instance, be considered again."

Anna—Dr. D. R. Milliette stepped down as president of the Anna Board of Education after concluding 48 years of continuous service. For 29 years he was clerk of the Board and for 17 years its president.

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(brand of phenylbutazone)

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Employing the serum protein-polysaccharide ratio (PR) as an objective criterion of rheumatoid activity, it has again been shown that BUTAZOLIDIN "...produces more than a simple analgesic effect in rheumatoid arthritis."¹

Clinically, the potency of BUTAZOLIDIN is reflected in the finding that 57.6 per cent of patients with rheumatoid arthritis respond to the extent of "remission" or "major improvement."²

Long-term study has now shown that the failure rate with BUTAZOLIDIN in rheumatoid arthritis, and particularly in rheumatoid spondylitis, is significantly lower than with hormonal therapy.³

(1) Payne, R. W.; Shetlar, M. R.; Farr, C. H.; Hellbaum, A. A., and Ishmael, W. K.: J. Lab. & Clin. Med. 45:331, 1955. (2) Bunim, J. J.; Williams, R. R., and Black, R. L.: J. Chron. Dis. 1:168, 1955. (3) Holbrook, W. P.: M. Clin. North America 39:405, 1955.

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Ethical Cases Considered . . .

Report of Judicial and Professional Relations Committee on Activities Of Laboratory and Policy on Telephone Listings Approved by Council

A REPORT from the Judicial and Professional Relations Committee, based on a meeting of the committee on January 22, 1956, was considered by The Council of the Ohio State Medical Association on March 11. The report and recommendations of the committee, reading in part as follows, were officially approved by The Council: (See Page 402)

* * *

A meeting of the Judicial and Professional Relations Committee of the Ohio State Medical Association was held at the Columbus Office on Sunday, January 22, 1956.

On invitation, Mr. Edward Pritchard, of the Ohio Bell Telephone Company, appeared before the committee to discuss a recommendation by his company for a new style in the listing of physicians in the yellow classified pages of the Ohio Bell Directory. As recommended, physicians would be listed alphabetically; also by specialty or special interest under special headings, such as "Allergic Diseases," "Nose and Throat," "Surgeons," etc. A special charge would be made for listing under the special heading, ranging from 50 cents to \$1.00, depending on size of city.

RE: TELEPHONE LISTINGS

The committee took the following action for consideration of The Council:

"It does not disapprove of the plan submitted by the Ohio Bell Telephone Company providing:

"1. It has the approval of the county medical society in each area where the plan would be put into effect;

"2. A foreword is published reading as follows or containing similar language: 'The information contained herein has been supplied by each physician listed.'

"3. The titles used for the various classifications and categories conform to specialty groups or special interest categories appearing in the American Medical Directory."

Mr. Pritchard stated he would discuss the recommendations of the committee with his superiors and advise the Association of their reactions.

CONFIDENTIAL COMMUNICATIONS QUESTION

A communication addressed to Chairman Doolley and signed by Doctor Richard R. Waite, director, North Central Ohio Mental Health Clinic, Tiffin, was discussed. The letter said, in part:

"At the request of the Ohio Psychiatric Clinic Directors Association, the following problem is placed before the Committee on Judicial and

Professional Relations of the OSMA. The Association requests your consideration and reply to this problem.

"In 1954 the Division of Mental Hygiene initiated a new statistical reporting system. Previously reports sent in to the division by individual clinics had been compiled summaries. The new system required the submission of an individual form for each patient. Such form, an IBM card, is attached. On this form, as you will see, the patient's name and his diagnosis are listed. In previous reports there was no such correlation except of course in the personal files of the individual physician. The association is concerned with whether this constitutes a violation of professional confidence."

The committee felt that additional information on this subject is required. It instructed the Executive Secretary to discuss the matter with Doctor Porterfield and others in the State Department of Mental Hygiene and secure information for consideration by the committee at a later meeting.

MORE ON TELEPHONE LISTINGS

Mr. Edward Willenborg, executive secretary of the Cincinnati Academy of Medicine, present by invitation, advised the committee that Cincinnati physicians who have been listing their names in the telephone directories in Butler and Clermont counties had cancelled such listings, at the suggestion of the Cincinnati Academy of Medicine. This question had been submitted to the Judicial and Professional Relations Committee of the OSMA and referred to the Cincinnati Academy of Medicine for investigation and action.

The committee took the following action:

"The physicians referred to have taken the proper action as it is the opinion of this committee that it is unethical and unprofessional for a physician to carry a telephone listing in the telephone directory of an area other than the one in which his bona fide office or offices are located."

The Cincinnati Academy of Medicine was thanked and congratulated for its action in this matter.

LABORATORY CASE CONSIDERED

The committee then considered a case of long standing involving a Cincinnati clinical-pathological laboratory. It had been charged that the laboratory and its medical director were parties to alleged solicitation of patients and alleged fee splitting as a result of promotional activities carried on by the laboratory and its plan of

THE NEW YORK POLYCLINIC MEDICAL SCHOOL AND HOSPITAL

(Organized 1881)

(The Pioneer Post-Graduate Medical Institution in America)

SURGERY AND ALLIED SUBJECTS

A two months combined surgical course comprising general surgery, traumatic surgery, abdominal surgery, gastroenterology, proctology, gynecological surgery, urological surgery. Attendance at lectures, witnessing operations, examination of patients pre-operatively and post-operatively and follow-up in the wards post-operatively. Pathology, radiology, physical medicine, anesthesia. Cadaver demonstrations in surgical anatomy, thoracic surgery, proctology, orthopedics. Operative surgery and operative gynecology on the cadaver; attendance at departmental and general conferences.

PRACTICAL ELECTROCARDIOGRAPHY

A two weeks part time elementary course for the practitioner based upon an understanding of electrophysiologic principles. Standard, unipolar and precordial electrocardiography of the normal heart. Bundle branch block, ventricular hypertrophy, and myocardial infarction considered from clinical as well as electrocardiographic viewpoints. Diagnosis of arrhythmias of clinical significance will be emphasized. Attendance at, and participation in, sessions of actual reading of routine hospital electrocardiograms.

DERMATOLOGY AND SYPHILOLOGY

A three year course, beginning in October, fulfilling all the requirements of the American Board of Dermatology and Syphilology. Also five-day seminars for specialists, for general practitioners, and in dermatopathology.

COURSE FOR GENERAL PRACTITIONERS

Intensive full time instruction covering those subjects which are of particular interest to the physician in general practice. Fundamentals of the various medical and surgical specialties designed as a practical review of established procedures and recent advances in medicine and surgery. Subjects related to general medicine are covered and the surgical departments participate in giving fundamental instruction in their specialties. Pathology and radiology are included. The class is expected to attend departmental and general conferences.

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Indicated
in most conditions
in which oral cortisone
or hydrocortisone is effective
• Available in 1 mg. and 2.5 mg.
tablets in bottles of 100, and in 5 mg.
tablets in bottles of 30, 100, and 500 •
Usual dosage is $\frac{1}{2}$ to 1 tablet three or four
times daily

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requires only $\frac{1}{3}$ the dose of hydrocortisone

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offering a discount on charges made to certain institutions.

Evidence and testimony were presented on behalf of the Subcommittee on Advertising of the Cincinnati Academy of Medicine. Oral testimony was presented by representatives of the Ohio Society of Pathologists and by the president and medical director of the laboratory in question.

After hearing all the testimony and carefully reviewing the evidence, the committee adopted a report for The Council's consideration. After reviewing the facts, the report stated that it was the opinion of the committee that the medical director's association and connection with the laboratory under consideration was "highly questionable." The report said that it is the feeling of the committee that the physician ought not be a party to solicitation or the giving of discounts, rebates or kick-backs, or any other activity of the laboratory which he could not ethically carry on as an individual physician; nor should he have any part in the control and management of a corporation which engages in such activity.

Use of Hypnosis To Be Subject At Bunts Institute Program

The Frank E. Bunts Education Institute has announced a program to be held April 10, 8:15 to 9:45 a.m. in the North Clinic Building, Cleveland Clinic, 93rd Street and Euclid Avenue, Cleveland. The subject, "The Use of Hypnosis in the Field of Medicine," by Dr. William S. Kroger, associate clinical professor of obstetrics and gynecology, Chicago Medical School. Dr. Kroger's film on the utilization of hypnotic techniques in labor and delivery will be shown. All physicians are invited.

Ohio State Gets Grant for Study On Hospital Services

Eleven research grants totaling \$401,960 for studies to aid in the improvement of hospital services were announced by Dr. Leonard A. Scheele, Surgeon General of the Public Health Service.

The grants were recommended by the Federal Hospital Council which met in Washington. These are the first grants to be made from an appropriation of \$1,200,000 for this purpose included this year in funds for the Hospital Survey and Construction Program.

One grant goes to Ohio State University, for study of development of methods by which factors affecting the care of hospital patients can be evaluated. It is for \$60,912. Daniel Howland, assistant professor of industrial engineering at the University's engineering experiment station, will be principal investigator.

All Ohio Mothers Will Be Notified Of Babies' Birth Registrations

Mothers of all Ohio babies born on or after January 1, 1956, will receive from the Ohio Department of Health a notice of each baby's birth registration, Dr. Ralph E. Dwork, director of the Department, announced.

This "Notice of Birth Registration" will include the child's name, place and date of birth and the number under which the original birth certificate is permanently filed. On the notification also is this statement: "This notification may be used to establish proof of age for entrance to school."

On the back of the card is a form, "Record of Your Child's Immunization," with the notation, "Ask your Doctor to fill in the date and sign his name. Keep this as a valuable permanent record."

The form lists Diphtheria, Whooping Cough, Tetanus, Polio, Smallpox and "Other" with spaces for noting date of first, second, third and booster shots, where appropriate, and space for the physician's signature.

The statement announcing this new service has this to say: "In view of the changing trends in medical thinking, any reference to the currently recommended time schedule for immunizations has been omitted." In other words, the spacing of immunizations is left to the family physician. It is suggested further that perhaps a separate leaflet giving specific information on immunization may accompany the birth registration notice.

There are other programs, too, which may be called to the attention of parents through inclusion of small leaflets: Accident prevention with particular reference to household poisons, the danger of lead paint, etc.

Recommended by the Health Commissioners' Conference, the birth registration notification program is being effected by the Ohio Department of Health through its Division of Vital Statistics and Child Hygiene.

One of the fundamental purposes of carrying out a birth registration notification program is to improve the completeness of birth registration, W. H. Veigel, chief of the Division of Vital Statistics, said. Ohio registers 99 per cent of its births, according to the last national test, but still there are approximately 2,250 births each year for which no certificates are filed. Furthermore, approximately 18 per cent of birth certificates filed contain errors or omissions or both.

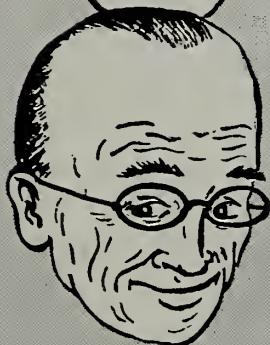
Bellefontaine—A community celebration sponsored by the local American Legion post was given in honor of Dr. A. J. McCracken, physician in the area for 50 years, Logan County coroner and active in Legion work for many years. Dr. McCracken received the 50-Year Pin from his medical colleagues in 1951.

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in ALL AGE

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...ACCURATE DOSAGE
...BUFFERED and VISCOLIZED
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**ANNUAL AUDIT OF BOOKS OF THE OHIO STATE MEDICAL ASSOCIATION AND THE
OHIO STATE MEDICAL JOURNAL FOR YEAR ENDING DECEMBER 31, 1955, BY
KELLER, KIRSCHNER, MARTIN & CLINGER, CERTIFIED PUBLIC
ACCOUNTANTS, COLUMBUS, OHIO**

OHIO STATE MEDICAL ASSOCIATION

Cash and Bonds on Hand, January 1, 1955:

Cash in Huntington National Bank	\$ 31,713.55
Cash in Ohio National Bank (dues paid in advance)	35,840.00
U. S. Treasury and Savings Bonds	80,000.00
Total Cash and Bonds on Hand, January 1, 1955	\$147,553.55

RECEIPTS

Interest on U. S. Treasury and Savings Bonds	\$ 2,052.00
1955 Membership dues collected in 1955	128,120.00
1956 Membership dues collected in 1955	39,840.00
1955 Exhibit space collected in 1955	8,587.50
1956 Exhibit space collected in 1955	6,555.00
Banquet tickets sold	1,757.00
Payment for collection of American Medical Association dues	1,658.03
1954 Checks Cancelled	116.50
Total Receipts	\$188,686.03

Total To Be Accounted For (Includes 1956 Dues and Exhibit Payments Collected in Advance) -- \$336,239.58

DISBURSEMENTS

Ohio State Medical Journal	\$ 27,000.00
Executive Secretary, salary	15,000.00
Executive Secretary, expense	1,255.37
President, expense	1,031.22
President-Elect, expense	189.25
Stenographic and clerical salaries	27,858.55
Council, expense	3,708.84
A. M. A. Delegates, expense	3,564.77
Dept. of Public Relations:	
Director, salary	\$12,500.00
Director, expense	1,810.41
Asst. Director, salary	7,500.00
Asst. Director, expense	1,703.04
Exhibits and newspaper publicity	45.00
Literature	1,434.29
Postage	1,513.54
Supplies	369.16
Miscellaneous Activities	2,539.37
	29,414.81

Standing Committees:

Public Relations and Economics	\$ 338.69
Scientific Work	734.18
	1,072.87

Special Committees:

Auditing and Appropriations	\$ 645.00
Chronic Illness	250.71
Industrial Health	625.23
Maternal Health	736.96
Medical Care of Veterans	666.87
Military Advisory Chairman, salary	3,000.00
Miscellaneous Committees	389.18
Rural Health	1,631.49
School Health	1,172.83
	9,118.27
Addressograph purchased	1,898.39
Annual Meeting	17,821.45
Checks reissued	111.50
Conference County Society Presidents and Secretaries	958.24
Insurance, bonding, taxes	2,167.72
Interest accrued on Treasury Bonds purchased	40.08
Legal expense	5,977.87

Postage	1,020.00
Professional Relations Activities	7,319.98
Rent and utilities	8,978.25
Retirement Fund	4,106.42
Rural Medical Scholarships	2,000.00
Stationery and supplies	3,977.85
Telegraph and telephone	1,994.04
Refunds: Exhibit space and dues	127.50
U. S. Treasury bonds purchased	10,000.00
Total Disbursements	\$187,713.24
Less transfer of funds for purchase of bonds	10,000.00
Total Net Disbursements	\$177,713.24

Cash on Deposit and Bonds on Hand, December 31, 1955:

Huntington National Bank	\$ 28,686.34
Ohio National Bank (dues paid in advance)	39,840.00
U. S. Treasury and Savings Bonds	90,000.00
Total Cash and Bonds on Hand, December 31, 1955	\$158,526.34

Total Accounted For (Includes 1956 Dues and Exhibit Payments, Collected in Advance) \$336,239.58

THE OHIO STATE MEDICAL JOURNAL

ASSETS

Current Assets:

Cash in Ohio National Bank	\$ 3,756.25
Petty Cash	20.00
Total Cash	\$ 3,776.25
Accounts receivable: Advertising	\$2,831.06
Postage deposit	125.00
Deposit paid City of Cleveland due from Ohio State Medical Association	500.00
	\$ 3,456.06
Total current assets	\$ 7,232.31

Property Assets:

Furniture and equipment (depreciated value)	15,664.08
Total Assets	\$ 22,896.39

LIABILITIES AND SURPLUS

Surplus, December 31, 1954	\$ 21,293.77
Net income for year ended December 31, 1955	1,602.62
Total surplus, December 31, 1955	\$ 22,896.39

STATEMENT OF PROFIT AND LOSS

Income:

Advertising, gross	\$ 51,418.45
Less: Commission on advertising	\$ 4,433.63
Cash discount on advertising	847.12
	5,280.75
Advertising income, net	\$ 46,137.70
Ohio State Medical Association appropriation	27,000.00
Subscriptions and sales	1,026.99
Ohio State Medical Association appropriation for addressograph machine	1,898.39
Miscellaneous receipts: Gift of EENT Section	\$ 263.27
Repayment of postage and supplies	91.92
	355.19
Total Income, net	\$ 76,418.27

Expenses:

Salaries	\$ 12,099.20
Journal printing	55,430.31
Journal postage	1,262.56
Stationery, printing and supplies	3,111.26
Illustrations and engravings	497.19
Travel expense	113.67
Depreciation	1,536.39
Miscellaneous postage	615.07
Miscellaneous expense	150.00
Total expenditures	\$ 74,815.65
Surplus for the year	\$ 1,602.62

All the benefits of **prednisone**
and **prednisolone**
plus **positive antacid**
action to minimize
gastric distress



Multiple Compressed Tablets of 'CO-DELTRA' and 'CO-HYDELTRA' are designed to help the physician cope with the problem of gastric distress which might otherwise become an obstacle to therapy with the newer steroids prednisone and prednisolone. Each Multiple Compressed Tablet is specifically formulated as a "tablet within a tablet" to provide stability and to release in sequence antacid and anti-inflammatory components.

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Licenses Granted . . .

December Examinations Result in 109 Graduates of Medical Schools Receiving Certificates To Practice Medicine and Surgery in Ohio

RESULTS of the examinations conducted by the State Medical Board of Ohio on December 15-17, 1955, were considered by the Board at its meeting of January 24, Dr. H. M. Platter, secretary, reported.

A total of 109 graduates of schools of medicine were authorized to receive certificates to practice medicine and surgery in the State. Also 30 graduates of osteopathic schools were authorized to receive certificates to practice osteopathic medicine and surgery.

In the limited branches, certificates were authorized for 6 chiropodists, 3 mechanotherapists, 4 chiropractors, 10 masseurs and 1 cosmetic therapist.

Highest grade in the examinations was made by Paul H. Ornstein, Cincinnati, a graduate of the University of Heidelberg, Germany, with an average of 89.4 per cent.

Two persons tied for second highest grade, both with 89 per cent. They are Charles E. M. Wenyon, Dayton, who received his medical degree from the University of Oxford, England; and James F. Rimel, Plymouth, Ind., a graduate of the State University of Iowa Medical College.

Following is the list of persons licensed to practice medicine and surgery. The list indicates residence at time of examination and medical college of graduation.

AMERICAN MEDICAL COLLEGES:

Duke University—Sam Silbergeld, Carlinville, Illinois.

Harvard University—Alvan Bradford Judd, Cincinnati.

Johns Hopkins University—Philip C. Pratt, Livermore Falls, Maine.

Jefferson Medical College—Robert W. Lukens, Jr., Columbus.

Marquette University—James J. Posch, Euclid; and John R. Somple, Akron.

Northwestern University—John E. Bennett, Akron; Albert J. A. Holm, Akron; Charles S. Lambdin, Burton; Harold G. Niemeyer, Akron; Robert W. Smith, Dayton.

Ohio State University—James B. Evans, Jr., Columbus; John C. Fischer, Toledo.

University of Iowa—James F. Rimel, Plymouth, Indiana.

Temple University—James A. Jones, Grove City, Pa.; William T. Paul, Columbus.

Tufts Medical School—John Sanberg, Brockton, Massachusetts.

University of Illinois—Donald M. Duckles, Cuyahoga Falls.

University of Pennsylvania—Angus M. Cameron, Minot, N. D.; Russell E. James, Kingston, Pennsylvania; Samuel K. McHutchison, Chardon; Douglas W. Sanders, Akron.

University of Pittsburgh—Martin F. Jones, Dayton; Warren W. Kaebnick, Dayton; Samuel Lowery, Toledo.

University of Washington—Henry A. Kuharic, Cincinnati.

University of Wisconsin—Armin R. Fuhlbrigge, Egg Harbor, Wisc.

University of Toronto, Canada—Alfred Bochner, Cleveland; Jesse Ketchum, Detroit.

FOREIGN MEDICAL COLLEGES:

Austria: University of Graz—Walter Pontasch, Toledo.

University of Vienna—Emmerich Antl, Vienna, Austria; Irina E. Driver, San Francisco, Calif.; Vladimir Nenoff, New York, N. Y.

Bulgaria: University of Sofia—Krum J. Mitroff, Welfare Island, N. Y.

Chile: University of Chile—Maurice M. Alcala, Chicago.

China: National Medical College of Shanghai—Ku-Yin Lin, Cleveland Heights.

St. John's University of Shanghai—Thomas C. H. Hwang, Columbus.

Colombia: National University of Colombia—Rafael Dominguez, Cleveland Heights.

Cuba: University of Havana—Remberto Rangel, Youngstown.

Czechoslovakia: University of Brno—Jan Sekanina, New York, Forest Hills, N. Y.

University of Prague—Gerd Leopoldt, Knoxville, Tenn.

England: University of Oxford—Charles E. M. Wenyon, Dayton.

France: University of Paris—Agenor Carle, LeMoule, Guadeloupe, French West Indies.

Germany: University of Dusseldorf—Valentins Berzzarins, Glen Gardner, N. Y.

University of Erlangen—Peter D. Argiroff, Brooklyn, N. Y.; Maria T. Dycio, New Brunswick, N. J.

University of Frankfurt-am-Main—George Mines, Brooklyn, N. Y.

University of Gottingen—Dimitry Chachutow, Clifton, N. J.; Hermann Velbinger, Lodi.

University of Hamburg—Hellmuth E. Simon, Columbus.

University of Heidelberg—Gerhart G. Hilt, Cleveland; Anna Ornstein, Cincinnati; Paul H.



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complains that the pain
of neuritis is unbearable,
THORAZINE*
will help you
allay his suffering*

'Thorazine' should be administered discriminately; and, before prescribing, the physician should be fully conversant with the available literature.

'Thorazine' acts not by eliminating the pain, but by altering the patient's reaction—enabling him to view his pain with a serene detachment. Howell and his associates¹ reported: "Several of [our patients] expressed the feeling that ['Thorazine'] put a curtain between them and their pain, so that whilst they were aware that the pain existed, they were not upset by it."

*Smith, Kline & French
Laboratories, Philadelphia*

1. Howell, T.H., et al.: *Practitioner* 173:172 (Aug.) 1954.

*T.M. Reg. U.S. Pat. Off. for chlorpromazine, S.K.F.

Ornstein, Cincinnati; Brigitte R. Rosenberg, Cincinnati; Philip H. Rosenberg, Cincinnati; Karl K. Targownik, Topeka, Kansas.

University of Innsbruck (Austria)—Zenon Gill, Trenton, N. J.; Orest M. Pawluk, Trenton, N. J.

University of Kiel—Peter Schroeder, Brooklyn, N. Y.

University of Marburg—Adolph Baltrukenas, Chicago.

University of Muenster—Viljams Blumentals, Canton.

University of Munich—Elena Deckys, Philadelphia, Pa.; Ciril Gostic, Cleveland; Michael Linver, New York, N. Y.; Walter K. E. Sprenger, Canton.

University of Rostock—Gunter A. Lamm, Cincinnati.

University of Tubingen—Albinas Smulkstys, Philadelphia, Pa.; Elmerice T. Traks, Cleveland.

University of Worzburg—Hans-Joachim Dietze, Knoxville, Tenn.; Bogdan M. Nedelkoff, Nutley, New Jersey.

Greece: University of Athens—Stephanos G. Cocorelis, Ann Arbor, Mich.

Hungary: University of Budapest—Joseph G. Erossy, Cleveland.

University of Debrecen—Martin Reiner, New York, N. Y.

University of Pecs—Ervin F. K. Wiktorin, St. Louis, Mo.

University of Szeged—Coloman de Chenar, Austin, Texas.

Ireland: National University of Ireland—Donal S. O'Leary, Wichita, Kans.

Italy: University of Gologna—Sylvester Centrone, Trenton, N. J.; Zvonimir J. Mihanovic, Canton; Augusto Mussone, Jersey City, N. J.; Joseph Nurenberg, Norton, Kansas; Kurt Witton, Marlboro, N. J.

University of Modena—Jacob Ungar, Brooklyn, New York.

University of Naples—Domenic Foglia, Rochester, N. Y.; Domenico Fragomeni, Cleveland.

University of Rome—Paul Illovosky, Brooklyn, New York.

Latvia: University of Latvia—Nikolajs Stukens, Canton.

Lithuania: University of Kaunas—Henrikas Brazaitis, Levittown, N. Y.; Nellie K. Juskenas, Cleveland; Joseph Silber, Brooklyn, N. Y.

University of Wilno—Henryk Bergman, Brooklyn, New York.

Mexico: National University of Mexico—Carlos A. Schaffenburg, Euclid.

University of Nuevo Leon—Americo G. Ramos, Albany, N. Y.

Netherlands: University of Utrecht—Ludolph H. Van der Hoeven, Columbus; Frans J. Barends, Columbus.

Philippines: University of Santo Tomas—Archer B. Parham, Jr., Louisville, Ky.

Poland: University of Lemberg—Irene S. Plaskacz, Rochester, N. Y.

University of Warsaw—Marc Balin, Brooklyn, New York.

Roumania: University of Timisoara—Ignatz Vidu, New York, N. Y.

Switzerland: University of Basel—Rudolf E. Schuldes, Alliance.

University of Geneva—Banjamin Wainfeld, Brooklyn, N. Y.

University of Lausanne—Bernhard Czernobilsky, Cincinnati; Arnold P. Gold, Cincinnati.

University of Zurich—Helen Geduldig, Jamaica, New York; Roy Geduldig, Jamaica, N. Y.; Edward Miller, Richmond Hill, N. Y.

U. S. S. R.: First Medical Institute of Kharkov—Ivan Mojssejenko, Nashville, Tenn.

Odessa Medical Institute—Paul G. Koussandianos, Odessa, Russia.

Yugoslavia: University of Zagreb—Borivoj Vyroubal, Cleveland.

University of Belgrade—Vladimir B. Wozniak, New York, N. Y.

* * *

Licensed Through Endorsement by State Medical Board

The State Medical Board has issued licenses to practice medicine and surgery in Ohio to the following physicians through endorsement of their licenses to practice in other states. (Intended residence given at time of application and medical school of graduation also are presented.)

October 4, 1955—Sylvester M. Bronson, Cincinnati, Univ. of Basel, Switz.; William K. Cotton, East Canton, Univ. of Rochester; Frank P. Gerold, Toledo, New York Univ.; Augustine S. Weekley, Jr., Youngstown, Boston University.

December 16—Joseph N. Aceto, Warren, Jefferson; Philip D. Anderson, Cuyahoga Falls, Univ. of Nebraska; Stanley Baublys, Univ. of Kaunas (Lithuania); Joseph P. Berger, Youngstown, Northwestern Univ.; Desmond G. Boyle, Cincinnati, Univ. of Birmingham (England); Douglas D. Brown, Cincinnati, Univ. of Durham (England); William A. Brown, Jr., Dayton, Howard Univ.;

Donald F. Cameron, Bryan, Hahnemann; John A. Cavins, Columbus, Johns Hopkins; William M. Chavis, Toledo, Meharry; Angelo S. Daniel, Johns Hopkins; Simon Dolin, Marion, Univ. of Kaunas (Lithuania); Joseph S. Dwek, St. Joseph Univ. (Lebanon); Marion M. Estes, Canton, Univ. of Georgia; Marvin Fish, Columbus, Vanderbilt University;

Harold H. Gist, Cleveland, Univ. of Virginia; Edward J. Gluck, Youngstown, New York Medical College; William D. Grant, Euclid, Univ. of Colorado; Gerald W. Grawey, Cincinnati, St.

(Continued on Page 426)

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to successful
IRON THERAPY



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IRON WITHOUT IRRITATION

**NO NAUSEA
NO ABDOMINAL CRAMPS
NO CONSTIPATION
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higher hemoglobin response

Supplied:

Fergon, tablets of 5 grains, bottles of 100 and 500.

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Fergon elixir 6% (5 grains per teaspoonful), bottles of 16 fl. oz.

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Louis Univ.; Sylvia D. Griva, Cleveland, Univ. of Buffalo;

Durell B. Horsley, Zanesville, Univ. of Virginia; Richard H. Hume, Cincinnati, Univ. of Michigan; Seymour Joffe, Cleveland, New York Univ.; Harold B. Kelly, Dayton, Howard Univ.; Mirosław Komarjanski, Brecksville, Univ. of Vienna; Wladimir Kuczerepa, Univ. of Innsbruck (Austria); Lowell W. Lapham, Shaker Heights, Harvard; Richard J. Lescoe, Columbus, Univ. of Pittsburgh; Leo Lucas, Urbana, Univ. of Bern (Switzerland);

Elisabeth H. McNaughton, Shaker Heights, George Washington Univ.; Dorothy Macy, Jr., Bryan, Woman's Med. Col. of Pennsylvania; George T. Mellinger, Cincinnati, Tulane Univ.; David Mendelsohn, Jr., Cleveland, Univ. of Pittsburgh; Marshall F. Nichols, Jr., Meharry; Benjamin Pasamanick, Columbus, Univ. of Maryland; Alena Polesny, Cincinnati, Univ. of Prague; Sidney Prystowsky, Toledo, Med. Col. of S. Carolina;

Michael I. Rehmar, Cleveland, Columbia Univ.; William C. Revercomb, Jr., Cleveland, Columbia Univ.; Wolf Rosenkranz, Toledo, Univ. of Prague; Don E. Sando, Dayton, Northwestern Univ.; Warren N. Sheldon, Elyria, Univ. of Minnesota; Elliott E. Stearns, Jr., Cleveland, Univ. of California; Stonewall B. Stickney, Tulane Univ.; Herbert S. Strauss, Univ. of Zurich (Switzerland);

Walter Weintraub, Univ. of Geneva, Switzerland); John C. Whitacre, II, Univ. of Minnesota; Frank A. Zack, Univ. of Maryland; John F. Ziegler, Cincinnati, Univ. of Chicago.

January 24—Phillip M. Allen, Hamilton, Harvard; Henry C. Blount, Jr., Marion, Vanderbilt; Edward E. Cale, Jr., Cincinnati, Tulane; Howard A. Coyer, Akron, Hahnemann;

Charles J. Dougherty, Cincinnati, Jefferson; Raymond J. Duffy, Duke Univ.; F. Margaret DuBois, Columbus, Univ. of Toronto (Canada); Robert N. Evers, Toledo, Washington Univ.; Jerome H. Finkelstein, Youngstown, Univ. of Michigan; Paul M. Fumich, Cleveland, St. Louis Univ.;

Joseph A. Kinge, Dayton, American Univ. of Beirut (Lebanon); Margaret A. MacLachlan, Cleveland, Univ. of Western Ontario (Canada); Theodore V. Parran, Cleveland, Johns Hopkins Univ.; Chester L. Plotkin, Cleveland, State Univ. of New York; Walter S. Price, Gallipolis, Univ. of Pennsylvania;

Robert F. Seymour, Cleveland, Howard Univ.; Benjamin M. Spock, Cleveland, Columbia Univ.; Roy J. Turner, Youngstown, Univ. of Arkansas; Milton Virshup, Cincinnati, Long Island College;

Wilburn Harold Weddington, Columbus, Howard Univ.; Stephen N. Wiener, Cleveland, Hahnemann; Ephraim Woll, Cincinnati, Creighton University.

Ohio State Radiological Society Meets in Columbus, May 11-13

The Ohio State Radiological Society will hold its annual convention and program in Columbus, Friday, Saturday and Sunday, May 11, 12 and 13, with Dr. George R. Krause, Cleveland Heights,

president, presiding. Sessions will be held in the Deshler-Hilton Hotel.

Other officers in addition to Dr. Krause are Dr. Donald English, Lima, vice-president; Dr. John R. Hannan, 10515 Carnegie Ave., Cleveland 6, secretary; and Dr. Paul Jones, Zanesville, treasurer.

All Ohio physicians interested are invited to attend.



G. R. KRAUSE, M. D.

The program has been announced as follows:

FRIDAY, MAY 11

Golf in afternoon at Scioto Country Club.
Dinner at the Scioto Country Club.

SATURDAY, MAY 12

- 8:00 A. M.—Registration
- 9:30—Dr. Henry C. Blount, Jr., Marion, "Pericardial Cysts—a Review of 18 Cases."
- 10:00—Dr. Samuel Brown, Cincinnati, "Roentgen Diagnosis of Pelvic Tumors."
- 10:30—Dr. Mortimer Lubert, Cleveland, "Tarsal Bars."
- 11:00—Dr. Edwin H. Ellison, Ohio State University, Columbus, "Findings and Significance of Abnormally Located Peptic Ulcers."
- 11:30—Dr. Charles A. Doan, Dean of the Ohio State University College of Medicine, "Combined Therapy of Certain Diseases of the Reticulo-Endothelial System."
- 12:00 Noon—Luncheon and Business Meeting.
- 2:00 P. M.—Dr. Ethel Blatt, University of Cincinnati, Cincinnati, "Congenital Anomalies of the Brain in Children."
- 2:30—Dr. Arthur S. Tucker, Cleveland Clinic, Cleveland, "Roentgen Diagnosis of Spinal Cord Tumors."
- 3:00—Dr. Robert L. Friedman, Columbus, "Intrapulmonary Effusions."
- 3:30—Dr. Orliss Wildermuth, University Hospital, Ohio State University, Columbus, "Radioactive Isotopes in the Management of Malignant Effusions, (with an exhibit demonstration)."
- 6:30—Dinner Dance

SUNDAY, MAY 13

- 10:00 A. M.—Brunch and Business Meeting.
- 12:00 Noon—Dr. Lee Rosenberg, Cincinnati, Moderator—Film Diagnostic Panel.

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^{*}Clinton, M., Round Table Discussion: New York J. Med. 54:481, 1954.
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In Our Opinion:

Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

SEE YOU AT THE POLLS ON MAY 8

Put down the date, May 8, on your appointment calendar. On that day you have a date with your obligation as a citizen. It's Primary Election Day. Unless you go to the polls on that day and cast your votes for your favorite candidates you will not be acting as a good citizen.

Party Primaries are far more important than many persons consider them. Remember that those who win at the General Election in the Fall can be no better or no worse than those nominated at the primary elections. Therefore, on May 8 you will have your first chance to pick those whom you believe to be worthy of public office.

May we suggest that you also talk up the primaries among members of your family, neighbors and patients.

See you at the polls on May 8!

NEW BRICKER PROPOSAL BEING CONSIDERED

The Bricker Amendment to curb the making of treaties which would conflict with the U. S. Constitution is again in the spotlight in Congress. Its supporters are optimistic. The proposal has been endorsed by the AMA, OSMA and many other medical societies, among hundreds of other organizations and groups.

Here is the newest development on the proposal, in case you want to write to your Congressman or discuss the matter with your friends.

By a vote of 11 to 2, the Senate Judiciary Committee has approved a modified version of the amendment. The new wording in the key section merely states: "A provision of a treaty or other international agreement which conflicts with any provision of this Constitution shall not be of any force or effect." Also retained are the requirements for a Senate rolleall vote on treaties and provision for the amendment to become effective after approval by legislature of three-fourths of the states within seven years.

In adopting the new language, the committee scrapped a part of the earlier Bricker proposal that read as follows: "A provision of a treaty or other international agreement which conflicts with this constitution or which is not made in pursuance thereof shall not be the supreme law of the land nor be of any force or effect. A treaty or other international agreement shall become effective as internal law in the United States only

through legislation valid in the absence of international agreement."

The revised proposal may not be as strong and all-inclusive as the original but some compromise apparently has been necessary to get agreement on the basic idea.

CARD FOR CORONARY PATIENTS SUGGESTED

A member writes as follows: "Any coronary patient or a patient who is on a regular medical treatment if of such a nature is subject to attacks that might, if seen on the street, make others think he is drunk or else an epileptic, and receive treatment or handling which would be very detrimental to his health."

Our correspondent then offers the suggestion that such patients "be required" for their own protection to carry a card which should carry name; phone number of nearest relative; age; physician's name, address and phone number; diagnosis in both medical and lay language; suggested emergency treatment.

We can't endorse the point that the carrying of such a card be "required." However, the idea has merit. Physicians who are taking care of heart patients might suggest the card idea to them, if they believe it is wise to do so.

MORE LEADERS LIKE BILL SKIPP NEEDED

In this issue of *The Journal* will be found a news item regarding the untimely death of Dr. William M. Skipp, Youngstown.

In our opinion, those who knew Bill Skipp and are familiar with his deep interest in the activities of his national, state and local medical societies will concur in the observation that he ranked among those who have made extraordinary contributions in advancing the objectives of those organizations.

As a young man, Dr. Skipp assumed leadership in his own local society. He did much to make it one of the best in the state. As a member of The Council of the State Association he did an outstanding job. As Councilor and later as President of the State Association, Bill made great sacrifices of time and devoted almost superhuman effort in carrying out his official duties. This loyalty and sense of responsibility carried over as he became one of Ohio's delegates to the AMA, serving with distinction in the official body of the national organization. Even

after reaching an age when many ask to be relieved of official duties. Dr. Skipp accepted the chairmanship of the Ohio committee named to boost the American Medical Education Foundation. It was typical of Bill, as he never side-stepped putting in good licks for the profession and its program. He never dodged an assignment.

Medical organization needs more Bill Skipp. They keep the wheels moving. Replacing them is difficult.

SALUTE FOR A 20-YEAR JOB WELL DONE

Twenty years ago, in fact on March 1, 1936, the words "Jonathan Forman, M. D., Editor" appeared for the first time on the masthead of *The Ohio State Medical Journal*. The anniversary of any twenty-year span in any activity warrants recognition. Therefore, the members of the Columbus Office staff who have assisted Dr. Forman in producing *The Journal*, join with the membership of the Association in saluting him for a job well done.

During the past twenty years, *The Ohio State Medical Journal* has remained in the front rank of state medical journals. It has been recognized repeatedly by experts as one of the best in its field.

During his tenure as editor, Dr. Forman has consistently followed the purpose he set for *The Journal* back in 1936, namely, that it should serve as a "house organ" for the Association. Specifically, the objectives have been to offer to members a media of communication between themselves and their officers in matters pertaining to their own society; keep the members informed of activities, including governmental and legislative activities, which concern the practice of medicine; report news about all groups and agencies engaged in the promotion of public health; and provide Ohio physicians with articles which add up to a postgraduate course in medicine.

In designing and cooperating in the production of such a magazine, Dr. Forman has had the approval and support of The Council throughout the years. Moreover, there has been harmony and cooperation between The Editor and all administrative employees of the Association, most of whom have some part, big or little, in the production of *The Journal*.

There have been great changes and many historical events in the period 1936-1956, all of which have had an impact on the practice of medicine and the medical profession. During that time, *The Journal* has endeavored to do a job for the membership. Thousands of members have made contributions in the form of clinical articles and other items for the columns of *The Journal*.

In the editorial columns of Vol. 1, No. 1, of

The Ohio State Medical Journal, issued in July, 1905, this statement appeared: "The Publication Committee desires to make *The Ohio State Medical Journal* the best state journal published and in order to accomplish this end, asks for the cooperation of every member of the State Association. The committee will be glad to receive suggestions or criticism from any member."

Judgment as to whether our magazine is "the best" will have to be rendered by others. We do feel, however, that the progress which *The Journal* has made during the past twenty years under the general guidance of Dr. Forman has made it a worthy contender for the honor. The request made in 1905 for cooperation, criticism and suggestions from the members is just as live today as it was fifty-one years ago.

Charles S. Nelson,
Executive Secretary.

'TAIN'T FAIR, BUT THIS IS AN ELECTION YEAR

Washington prophets say chances for passage now of legislation like the Jenkins-Keogh bills—tax relief for self-employed persons who are in organized retirement plans (physicians, lawyers, dentists, etc.)—are slim.

It's all tied in with the big question of tax relief for everyone. Dope is that members of Congress are reluctant to vote tax relief for self-employed (a special group) before tax relief is voted for citizens generally.

It's too early to know what, if anything, will be done for taxpayers generally. Therefore, the bill to aid the self-employed has been placed on the shelf.

'Tain't fair, you say? Probably not, but it's politics and this is an election year. The facts of life always become more clear in an election year.

HOOVER PROPOSALS GATHERING DUST

Last year the Hoover Commission submitted 29 proposals which would produce efficiency and economy in the Federal medical and hospital services. They included: Establishment of a Federal Advisory Council of Health; closing of Public Health Service general hospitals and abolition of free medical care for merchant seamen; retrenchment of veterans' hospitalization; contributory health insurance for employees of Federal government.

To date not a single one of the 29 proposals has been enacted by Congress or put into effect by executive order.

In other words, the record on the latest Hoover Commission recommendations is one of what hasn't been done on them. You might drop your Congressman a line. Ask him how come?

In Memoriam . . .

William Marshall Skipp, M. D., Youngstown; Ohio State University College of Medicine, 1918; aged 63; who was President of the Ohio State Medical Association in 1940, died on March 14.

Ohio lost an outstanding professional man and a tireless worker in the field of medical organization with the death of Dr. Skipp. His professional life in Youngstown began when he undertook intern and residency training at Youngstown Hospital in 1918. He became associated with the late Dr. Armin Elsaesser in 1920 and continued that association for many years, specializing in surgery of the neck and in endocrinology. He began professional teaching as a student assistant in medical school and for years was instructor in the Nurses' Training School of Youngstown Hospitals.

As early as 1921 Dr. Skipp became one of the most active members of the Mahoning County Medical Society and over a period of years served as chairman of almost every committee in the



WM. M. SKIPP M. D.

Society being particularly active in legislative affairs. In 1936 he was elected secretary and held that office for five years; after that being elected successively vice-president and president. Dr. Skipp was the founder of the Allied Professions Committee of Mahoning and Trumbull Counties and served as chairman of that organization for many years.

He was first elected to The Council of the Ohio State Medical Association in 1935 and was named President-Elect in 1939, succeeding to the Presidency the following year. He has since been on numerous state committees, including the Legislative Committee and the Ohio Campaign Committee for the American Medical Education Foundation, of which he was chairman. He served continuously as a delegate to the AMA beginning in 1941 and prior to that time was for several years an alternate delegate. Dr. Skipp was one of the founders of Ohio Medical Indemnity and served several years on its Board of Directors.

At the time of his death, he was delegate of the Mahoning County Medical Society to the State Association and on the editorial staff of the Mahoning County Bulletin, as well as being a delegate to the AMA.

He was a Fellow of the American College of Surgeons, Fellow of the International College of Surgeons, diplomate of the American Board of Surgery, member of the Society for Study of

Endocrines, member of the American Goiter Association and past-president of the Alumni Association of the Ohio State University College of Medicine. He was also active in civic and fraternal organizations, being a member of Nu Sigma Nu, the Youngstown Chamber of Commerce, the Masonic Lodge, an elder in the Presbyterian Church and active in other organizations. He is survived by his widow, two sons, a daughter, a sister and three brothers.

W. Harry Alicki, M. D., Cleveland; Poletchnic Institute, Mexico, 1948; aged 37, died February 18. Dr. Alicki had done residency work at St. Elizabeth Hospital in Youngstown and at several hospitals in Cleveland. His parents survive.

Carroll Behymer, M. D., Cincinnati; Eclectic Medical College, Cincinnati, 1898; aged 80; died February 19. Dr. Behymer practiced for a short time in California, Ohio, and in New Richmond, but the greatest part of his more than 50 years of practice was in Cincinnati. His widow and two sons survive.

Frederick G. Carter, M. D., Shaker Heights; Johns Hopkins University Medical School, 1920; aged 67; died February 19; member of the Ohio State Medical Association through 1949. Early in his career Dr. Carter went into hospital administration and distinguished himself in that field. He left Ancker Hospital in St. Paul, Minn., in 1935 to become administrator of Christ Hospital in Cincinnati. Four years later he became superintendent of St. Luke's Hospital in Cleveland. He left the hospital in 1954 to devote his time to special consulting work for hospitals in the area. He was president of the American Hospital Association in 1939-1940; and was a past-president of the Minnesota Hospital Association, the American College of Hospital Administrators and the Ohio Hospital Association. He was recipient of the Award of Merit of the American Hospital Association in 1952. Survivors include his widow, a daughter and two brothers.

Augustus John Dell, M. D., Muncie, Ind.; Miami Medical College, Cincinnati, 1901; aged 78; died February 2; member of the Ohio State Medical Association and the American Medical Association. A native of Middletown, Dr. Dell practiced there from 1901 until 1925. In that year he

moved to California, returning to Middletown in 1943 as city physician—a position he held until 1952. Dr. Dell was a recipient of the 50-Year Pin and Certificate of the Ohio State Medical Association. He was a member of the Masonic Lodge. Surviving are a son with whom he was making his residence in retirement, a daughter, a sister and two brothers.

William H. Delscamp, M.D., Dayton; Medical College of Ohio, Cincinnati, 1900; aged 85; died February 26; member of the Ohio State Medical Association through 1954; diplomate of the American Board of Radiology. A life resident of the Dayton area, Dr. Delscamp practiced medicine for 56 years, and was a recipient of the State Association's 50-Year Award. He was a pioneer in radiology in Dayton. Affiliations included memberships in the Episcopal Church and several Masonic bodies. Survivors include his widow, a daughter and a sister.

Charles E. Eha, M.D., Hyde Park (Cincinnati); Pulte Medical College, Cincinnati, 1909; aged 69; died February 8; member of the Ohio State Medical Association; the American Medical Association; Fellow of the American College of Surgeons. Dr. Eha practiced in the Hyde Park area for more than 40 years, serving as secretary of the Bethesda staff for 20 years and chief of staff for several years. He was a member of the Historical and Philosophical Society, several Masonic bodies and the Cincinnati Country Club. Survivors include his widow, a son, a daughter and a brother.

Mathias Steven Gedo, M.D., Lorain; German University of Prague, 1923; aged 57; died February 7; member of the Medical Society of the State of New York and the American Medical Association. A native of Czechoslovakia, Dr. Gedo received his education in that country. He had practiced in New York City since 1941 and had just come to Lorain to set up practice. Survivors include his widow, a son and two brothers.

Nunzio S. Giardino, M.D., Ohio State University, 1927; aged 59; died March 1; member of the Ohio State Medical Association. Dr. Giardino had been a practicing physician in Lorain for many years. His widow survives.

Adolphus W. Guest, M.D., San Diego, Calif.; Western University of London, Ontario, 1897; aged 86; died February 20; former member of the Ohio State Medical Association; member of the American Psychiatric Association. Dr. Guest was a former member of the staff of the Athens State Hospital from 1929 to 1940. Prior to that he had been superintendent of the North Dakota State Hospital. He retired in 1940 and moved to California. His widow and a son survive.

Hermann Heinrich Hartmann, M.D., Galion; Columbus Medical College, 1890; aged 85; died February 13; member of the Ohio State Medical

Association and the American Medical Association through 1952; past-president of the Crawford County Medical Society. A native of Galion, Dr. Hartmann was a practicing physician and leading figure in the civic and political life of the city over a period of nearly 66 years. He was mayor of Galion for 10 terms and a leader in the local Democratic organization. At the last session of the Ohio General Assembly the House of Representatives memorialized Dr. Hartmann in a special resolution for his service to the community, and in 1953 the local Chamber of Commerce honored him during the Ohio Sesquicentennial celebration. His widow and three daughters survive.

Edgar Harvey Johnston, M.D., Alexandria; Ohio Medical University, Columbus, 1901; aged 80; died February 9; member of the Ohio State Medical Association and the American Medical Association; past-president of the Licking County Medical Society. A native of nearby Pataskala, Dr. Johnston moved to Alexandria upon completion of his education and practiced more than a half century before he retired in 1952. He was recipient of the State Association's 50-Year Award. A veteran of World War I, he was a member of the American Legion. Other affiliations included membership in several Masonic bodies, the Knights of Pythias and the Baptist Church. He also was active in business life of the community, being a former president of the local bank and member of the library board. Survivors include his widow, a son and a sister.

Edwin Khuon, M.D., Cincinnati; Medical College of Ohio, Cincinnati, 1893; aged 87; died February 27; member of the Ohio State Medical Association and the American Medical Association through 1954. Dr. Khuon practiced his profession for more than 60 years in the Mohawk area and had been recognized with the 50-Year Award of the State Association. He was a member of the Veteran Druggists Association, having been in pharmacy work during his earlier years. Active in civic and fraternal work, he was a member of several Masonic bodies; also a member of the Federated Civic Association, the Kiwanis Club and the Mohawk Business Men's Association. Survivors include his son, Dr. Robert E. Khuon, also of Cincinnati, and a sister.

Roswell F. MacHamer, M.D., Tiffin; Western Reserve University School of Medicine, 1920; aged 66; died February 28; member of the Ohio State Medical Association and the American Medical Association. Dr. MacHamer served all of his medical career in Tiffin where he was active in many community affairs. He was a trustee of Heidelberg College, a director of the Chamber of Commerce, a former long-time member of the local board of health, a member of several Masonic bodies, the Evangelical and Reformed Church, the Elks Lodge, Rotary Club and Junior Order of Mechanics. He was physician for some

of the local homes and school athletic groups. His widow and a son, Dr. R. Wenner MacHamer, of Shaker Heights, survive.

Angus MacIvor, M. D., Marysville; Starling Medical College, Columbus, 1904; aged 79; died February 11; member of the Ohio State Medical Association and the American Medical Association. Dr. MacIvor was on the staff of the Columbus State Hospital before he moved to Marysville in 1906 as a staff member of the former Marysville Sanitarium. He entered private practice in 1910 and practiced in Marysville until his retirement in 1950, with the exception of a period from 1916 to 1922. As a member of the Ohio National Guard he was called into service in 1916 and after serving on the Mexican Border went to France during World War I. After the war he went into public health service and returned to his private practice in 1922. He was a member of the Kiwanis Club, several Masonic bodies, the American Legion, the Veterans of Foreign Wars, the Presbyterian Church. He is survived by two sons, one of whom is Dr. Malcolm MacIvor, also of Marysville, and two sisters.

Robert Reyburn McClellan, M. D., Xenia; Harvard Medical School, 1919; aged 64; died February 3; member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Surgeons; past-president of the Greene County Medical Society. Dr. McClellan began his practice in Xenia in 1918 and was associated for many years as chief of staff and president of the board of directors of McClellan Hospital, founded by his father. He was a member of the American Legion and the United Presbyterian Church. Surviving are his widow, a son, Dr. Harvey B. McClellan, Xenia, three daughters and three sisters.

Edith M. Offerman, M. D., Pemberville; Ohio State University College of Medicine, 1920; aged 73; died February 17; member of the Ohio State Medical Association and the American Medical Association; diplomate of the American Board of Internal Medicine. Dr. Offerman for many years practiced in Columbus where she was also on the staff of the Columbus State School. She retired in 1950 and moved to Pemberville which formerly had been her home. Dr. Offerman was a member of the American Association of University Women, the Lutheran Church and the Ursula Cotta Society. Three sisters survive.

Raymond Arthur Palmer, M. D., Toledo; University of Michigan Medical School, 1910; aged 71; died February 12; member of the Ohio State Medical Association and the American Medical Association. A native of Lucas County, Dr. Palmer completed an internship at St. Vincent's Hospital in Toledo and began his practice in Fostoria. He returned to Toledo many years ago and continued his practice there.

Jacob D. Rose, M. D., Portsmouth; Miami Medical College, Cincinnati, 1909; aged 70; died February 1; member of the Ohio State Medical Association and the American Medical Association; Dr. Rose during his early years of practice had a varied career in medicine which took him to several states, and to Europe for studies in dermatology. He moved to Portsmouth from Detroit in 1929. Beginning in 1936 he served two terms as Scioto County coroner. Affiliations included memberships in several Masonic bodies. Two sons survive.

Robert E. Ruedy, M. D., formerly of Cleveland Heights; Western Reserve University School of Medicine, 1893; aged 87; died February 12 in Newbury where he was making his home with a son. Dr. Ruedy practiced in the Greater Cleveland area for approximately 40 years. From 1916 to 1945 he was a member of the City Council of Cleveland Heights. Two sons survive.

George Platt Tyler, Sr., Ripley; Ohio Medical College, 1886; aged 91; died February 6; member of the Ohio State Medical Association through 1947 and former Fellow of the American Medical Association. Upon completion of his education, Dr. Tyler began practice on an Indian Reservation in Oregon, but returned to practice in Ripley 1888. He was a member of a pioneer family of the vicinity. With the exception of a short period in Manchester, where he also served as mayor, Dr. Tyler continued his practice in Ripley until after World War II and took an active part in civic, fraternal and business life of the community. He was a former coroner of Brown County, a former member of the Ripley Council, a former member of the Ripley Board of Public Affairs. Other affiliations included membership in the Methodist Church and several Masonic bodies. Survivors include his son, Dr. George P. Tyler, Jr., with whom he made his residence and two brothers.

Rolland John Whitacre, M. D., Shaker Heights; Hahnemann Medical College, 1933; aged 46; died February 16; member of the Ohio State Medical Association, the American Medical Association, the American Society of Anesthesiologists, diplomate of the American Board of Anesthesiology. Dr. Whitacre's untimely death took him from a position of outstanding achievement in medicine and a role of leadership in medical organization work. A pioneer in the field of anesthesiology as a medical specialty, Dr. Whitacre founded the Department of Anesthesiology at Huron Road Hospital in 1935 and headed it since. He was president of the American Board of Anesthesiology; past-president and director of the American Society of Anesthesiology; past-president of the Academy of Anesthesiology; executive secretary and a member of the Board of Trustees of the International Anesthesia Research Society; past-president of the Section on Anesthesiology

of the Ohio State Medical Association and the American Medical Association; past president of the Cleveland Society of Anesthesiologists and the Ohio Society of Anesthesiologists. Dr. Whitacre was a member of the Joint Committee on Accreditation of Hospitals; he was chairman of the Committee on Professional Services of the Academy of Medicine of Cleveland; he was associate editor of *Anesthesia*, and editor and founder of *Anesthesia Digest*. Approximately 28 papers were his contribution to medical literature. Dr. Whitacre is survived by his widow, a daughter, his parents, a sister and a brother.

Heart and Blood Vessels Will Be Discussed In Sandusky, May 2

A program on "Diseases of the Heart and Blood Vessels" for physicians is being presented Wednesday afternoon, May 2, from 2 until 5:15 P. M., Providence Hospital, Sandusky, it was announced by Dr. Arthur Groscost, president of the Erie County Heart Association.

Participating on the program will be Dr. F. Mason Sones, Cleveland, discussing "Congenital Heart Disease"; Dr. George Wright, Cleveland, "Relation of Cardiac Pulmonary Diseases"; and Dr. Hugh Hull, "Rheumatic Valvulitis." Dr. R. W. Kissane, of Columbus, will speak on "Conversion of Auricular Fibrillation" at a dinner meeting that evening.

Invitations will be mailed to all physicians in Erie, Ashland, Huron, Seneca, Ottawa, Wayne, Medina, and Sandusky Counties, but physicians elsewhere are invited to attend.

Dr. W. P. Skirball, Sandusky, is program chairman.

AMA Offering New Exhibits for Public on Eye and Ear

Scheduled for release this spring are two new AMA health exhibits depicting different aspects of the human body. Developed by the Bureau of Exhibits, both displays feature life size three dimension models of parts of the body.

The first, entitled "We See," is being released April 1. Charts and diagrams show construction of the normal eye in comparison to a camera, and various panels deal with nearsightedness, farsightedness, and color blindness. A special feature of this exhibit will give viewers an opportunity to check themselves on whether or not they have any eye deficiencies.

The second exhibit, "We Hear," stresses the mechanics of hearing, showing how sound enters the ear and is carried to the brain. Also featured are panels on motion sickness, quackery in the field and the mechanics of hearing aids. This exhibit will be available about May 1.

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Do You Know? . . .

The University of Cincinnati presented the 19th annual Roger S. Morris Memorial Lecture on March 6. Guest speaker for the occasion was Dr. Stanley E. Bradley, associate professor of medicine, Columbia University, whose subject was "The Physiology of Splanchnic Circulation in Health and Disease."

* * *

Dr. Thomas E. Shaffer, Columbus, has been appointed a member of the Committee on Child Health of the American Public Health Association.

* * *

The Southwestern Ohio Society of General Physicians in collaboration with the College of Medicine of the University of Cincinnati presented a program on March 4 on the theme, "Minor Surgical Procedures." Taking part in the program were the following physicians: Drs. Ralph Carothers, Joseph Freiberg, N. J. Giannestras, Robert Perlman, Vinton E. Siler, Theodore H. Vinke and Edgar H. White.

* * *

The Akron District Heart Association is co-operating with the Akron Health Department in a pilot study in the treatment of streptococcal sore throat diseases, as a means of preventing rheumatic fever. Two schools, Fairlawn and Lincoln, have been selected for this research study. The study will be conducted for one year.

* * *

At the recent meeting in Chicago of the Radiological Society of North America, Dr. Clarence E. Hufford, of Toledo, was elected to the position of president.

* * *

Dr. Richard J. Plunkett, secretary of the AMA Council on Mental Health, has been granted an extended leave of absence to serve as associate director of the newly-created Joint Commission on Mental Illness and Health, Inc., which has its headquarters at 808 Memorial Drive, Cambridge, Massachusetts, but will continue to serve on a part-time basis as secretary of the Council on Mental Health.

* * *

Dr. V. R. Frederick, Urbana, has been elected Regional Vice-President for Region Six, of the American Iris Society. This area covers Ohio, Michigan, and Indiana.

* * *

The Putnam County Board of Health has entered a cooperative agreement with Defiance County for a full-time health department under the administration of Dr. J. T. Holtzmuller, of Defiance. Putnam County was without a health commissioner following the retirement of Dr. H. A. Neiswander, of Pandora.

**"The substitution of oral
Neohydrin
for parenteral meralluride
was successfully
accomplished in 97 per cent
of 70 ambulatory
clinic out-patients with
chronic congestive
heart failure."***

*Lawrence, W. E.; Kahn, S. S., and Riser, A. B.:
South. M. J. 47:105, 1954.

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Activities of County Societies . . .

First District

(COUNCILOR: CHARLES T. ATKINSON, M. D.,
MIDDLETOWN)

CLINTON

A series of lectures on medical subjects in the Wilmington High School was sponsored by the Clinton County Medical Society. On the program to give these lectures were Dr. Edmond K. Yantes, Dr. Maxine Hamilton, Dr. Arthur F. Lippert, Dr. Nathan Hale and Dr. H. Richard Bath.

At the February 6 meeting in Wilmington, Dr. Robert Conard, county health commissioner, reported on the new forms for reporting communicable diseases and discussed the polio program in the county.

Dr. John K. Williams spoke on the duties of the coroner's office.

Dr. W. K. Kraeling, who began practice in Clarksville recently, was introduced at the meeting.

HAMILTON

The Academy of Medicine of Cincinnati is currently staging a series of TV shows over Cincinnati's educational station, WCET. The 13-week series will tell the history of the Academy, and in future programs reveal how it operates to the benefit of the community.

Emcee for the program is Peter Grant, Cincinnati's dean of news commentators. Dr. Joseph Ghory is acting as technical advisor for the series. Dr. Charles Sebastian, president of the Academy, and Edward Willenborg, executive secretary, appeared on the first program of the series.

"Anxiety"—its central place in psychiatric theory and practice and the increasing attention it is receiving in general medicine and surgery—was discussed by Dr. Philip F. D. Seitz, of the Institute for Psychoanalysis, Chicago, at the February 21 meeting of the Academy of Medicine of Cincinnati.

Second District

(COUNCILOR: G. A. WOODHOUSE, M. D.,
PLEASANT HILL)

GREENE

In March members of the Greene County Medical Society were entertained by members of the

Auxiliary at a dinner meeting. Speaker for the occasion was Richard Anderson, of the Battelle Institute of Columbus.

MIAMI

"Management of Head Injuries" was the subject discussed at the March 2 meeting of the Miami County Medical Society in the Dettmar Hospital, Troy. The speaker was Dr. Harry LeFevre, Department of Neurosurgery, Ohio State University.

MONTGOMERY

The 300 physicians, their wives and guests who attended the annual inaugural meeting of the Montgomery County Medical Society heard the President of the Society's 107th year emphasize what has been called a long neglected side of the patient-physician problem.

Dr. Frank L. Shively, Jr., installed as president for 1956, outlined a program of patient education with a goal of showing the patient's responsibility to the physician and what he must do to be a good patient. Also stressed was the need for medical society leadership in an all-round safety program, a project for the improvement of rest home facilities and a promotion program urging the people of the community to secure family doctors.

The General Practice Section meeting of the Society met on February 15 at Suttmiller's Restaurant for a luncheon meeting. Speaker was Dr. Philip Andrews who spoke on the subject, "The Use of the EEG in General Practice." The Section met at the same place on March 21 at which time Dr. J. G. Tye conducted an x-ray seminar.

The Dayton Obstetrical & Gynecological Society met on the evening of March 21 at the Van Cleve Hotel for a social hour, dinner and meeting. Dr. S. B. Gusberg, professor of obstetrics and gynecology, Columbia Presbyterian Medical Center, New York, spoke on the subject, "The Choice of Treatment for Cancer of the Cervix."

SHELBY

Dr. A. B. Gudenkauf, Sidney, recently was presented the 50-Year Pin and Certificate of the Ohio State Medical Association, in recognition of his faithful service in the medical profession

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over a half century. Dr. George A. Woodhouse, Pleasant Hill, Councilor of the Second District, presented the award at Dr. Gudenkauf's home. Dr. Gudenkauf began the practice of medicine in 1905 after graduating from Ohio Medical University in Columbus.

Third District

(COUNCILOR: JAMES R. JARVIS, M. D., VAN WERT)

ALLEN

Dr. Edwin Gerrish, assistant professor of pediatric surgery at University Hospital, Cleveland, spoke on "Abdominal Surgery of Infancy," at the February 13 meeting of the Lima and Allen County Academy of Medicine. The dinner meeting was held at the Shawnee Country Club.

Fourth District

(COUNCILOR: PAUL F. ORR, M. D., PERRYSBURG)

LUCAS

The program of the Academy of Medicine of Toledo in March included the following features:

March 2—General meeting, a joint meeting of physicians and medical assistants.

March 9—Pathology Section—"The Lesions and Pathogenesis of the Collagen Diseases," Dr. Robert H. More, professor of pathology, Queens University, Kingston, Ontario.

March 16—Medical Section—"Treatment of Uremia," Dr. W. J. Kolff, Research Division, Cleveland Clinic.

March 23—Specialists Section—"Significance of the EEG," Dr. Clark T. Randt, University Hospital, Cleveland.

The Inter-Hospital Postgraduate Lecture Series presented by the Medical Advancement Trust of the Maumee Valley Hospital and the Northwestern Ohio Heart Association was held on March 29 and 30 in the headquarters building of the Toledo Academy of Medicine.

Guest speaker was Dr. William Likoff, chief cardiologist, Bailey Thoracic Clinic, Philadelphia,

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Pennsylvania, whose theme was "The Pathophysiology, Clinical Manifestations and Therapy of Congenital and Acquired Heart Disease."

SANDUSKY

Dr. Morris Selman, Toledo, addressed the February 15 dinner-meeting of the Sandusky County Medical Society at Serwin's Restaurant, where he discussed the operation for coronary artery disease developed by Dr. Claude S. Beck.

Fifth District

(COUNCILOR: GEORGE W. PETZNICK, M. D., CLEVELAND)

CUYAHOGA

The Annual Meeting of the Academy of Medicine of Cleveland was held on February 17. Guest speaker was Dr. Walter C. Alvarez, nationally known physician, author and editor, whose announced subject was "My Crazy Library."

On February 15 the Academy participated in a closed circuit television reception in the Medical Library Auditorium. The subject discussed was "The Cardiac Patient in Stress: In Work, Surgery and Pregnancy."

A meeting of the Section on Surgery of Trauma was held on February 10.

Also a meeting of the Experimental Medicine Section was held on February 20 in conjunction with the Society for Experimental Biology and Medicine.

Sixth District

(COUNCILOR: CARL A. GUSTAFSON, M. D., YOUNGSTOWN)

MAHONING

The *Youngstown Vindicator* devoted considerable space to the report of a heart program sponsored jointly by the Mahoning County Medical Society, the Youngstown Area Heart Association and the Mahoning Academy of General Practice.

Guest speaker for the program was Dr. Joseph B. Vander Veer, head of the Cardiovascular Department, Pennsylvania Hospital, Philadelphia, and associate professor of cardiology, Graduate School of Medicine, University of Pennsylvania.

Conferences were held in the morning at South Side Unit of Youngstown Hospitals and in the afternoon at North Side Unit.

Dinner was held at the Youngstown Club followed by a lecture by Dr. Vander Veer on the subject, "Management of Patients Severely Ill with Acute Myocardial Infarction." This meeting alone was attended by approximately 125 persons.

Taking leading roles in the combined meeting were Dr. W. H. Bunn, president of the Youngstown Area Heart Association; Dr. Gabriel E. DeCicco, president of the Mahoning County Medi-

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cal Society, and Dr. Asher Randell, president of the Mahoning Academy of General Practice.—Information from Clyde K. Walter, M. D.

STARK

Dr. Roger B. Scott, of Western Reserve University Medical School, gave an interesting lecture on "The Technique of Cervical Biopsy in Relation to Suspicious or Positive Papanicolaou Slide Studies."

The March 8 meeting was held at Belden Hotel in Canton where Dr. F. A. Simeone, professor of surgery, Western Reserve, spoke on "Peripheral Vascular Disease."

Dr. A. Carleton Ernstene and Dr. William Proudfit, of the Cleveland Clinic, addressed physicians interested in heart disease at a dinner meeting at the Mergus Restaurant on March 22.

Seventh District

(COUNCILOR: ROBERT HOPKINS, M. D., COSHOCTON)

BELMONT

The Belmont County Medical Society met on March 15 at the City Restaurant in Bellaire. Dr. Homer Ring gave a report on the recent meeting of the American College of Surgeons in Philadelphia. Dr. Angelo Daniels presented a discussion on the subject, "Trends in Abdominal Surgery."

The February 16 meeting of the Society was held at the Martins Ferry Hospital where staff members gave a series of case presentations.

Eighth District

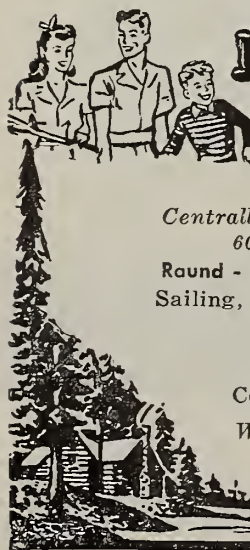
(COUNCILOR: ROBERT S. MARTIN, M. D., ZANESVILLE)

GUERNSEY

The Guernsey County Medical Society met at the Berwick Hotel in Cambridge on February 2 with 20 members present. A discussion and slide presentation was given by Dr. J. D. Knapp on eye conditions.

WASHINGTON

There were 29 persons present, including visiting physicians from Parkersburg and McConnells-



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ville for the February 8 dinner meeting of the Washington County Medical Society in Hotel Lafayette, Marietta. Dr. Bruce C. Martin, Columbus, discussed "The Modern Scope of Plastic Surgery." Dr. Edgar Northrup, president of the Society, presided at the meeting.

Ninth District

(COUNCILOR: C. L. PITCHER, M. D., PORTSMOUTH)

SCIOTO

"Heart Diseases in Children," was discussed by Dr. Don M. Hosier, Children's Hospital, Columbus, at the February 13 meeting of the Scioto County Medical Society in Portsmouth.

Tenth District

(COUNCILOR: E. H. ARTMAN, M. D., CHILLICOTHE)

FRANKLIN

"Diseases of the Abdominal Aorta and Large Arteries" was the subject discussed at the February 20 meeting of the Columbus Academy of Medicine by Dr. Walter F. Kvale, associate professor of medicine, the Mayo Foundation, University of Minnesota, Graduate School, and consultant in medicine at the Mayo Clinic.

On March 1 Mr. William Webb, Jr., began his new duties as assistant executive secretary of the Columbus Academy of Medicine—an event which completed the reorganization plan voted by Academy members last September. Mr. Stanley Mauck continues to serve as executive secretary, devoting his time to the Academy and to his duties as director of the Columbus Bureau of Medical Economics. Mr. Webb for the past four years has been executive secretary of the Columbus Milk Distributors Association.

Eleventh District

(COUNCILOR: H. T. PEASE, M. D., WADSWORTH)

ERIE

The Erie County Medical Society held its annual social meeting the evening of February 18, at the Log Cabin Inn in Sandusky. The evening began with a short cocktail period, followed by a steak dinner. Following the dinner, Dr. Dean Sheldon presented movies of wild life in color. This part of the program was followed by dancing. About 25 members and their wives attended, and were honored by the presence of Dr. H. T. Pease, of Wadsworth, Eleventh District Councilor, and Mrs. Pease. The affair was arranged by the entertainment committee consisting of Drs. W. P. Skirball, Paul LaFollette and Dean Sheldon.

A regular meeting of the Society was held at Providence Hospital on February 23. After a short business session, the meeting was turned over to the program committee and Dr. William Seiler introduced the speakers: Dr. Eric Clark, Dr. Eugene Zanger and Mr. William O'Connor, of the Mental Guidance Clinic. Their presentation was interesting and elicited ample discussion and questions.—S. R. Hoover, M. D., Secretary.

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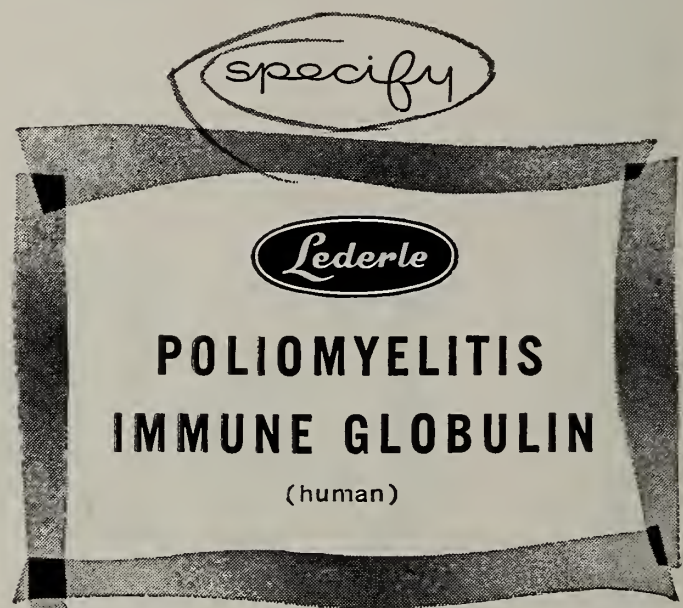
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Corresponding Secretary—Mrs. J. M. McBride, 808 Pears Ave., Lima
Treasurer—Mrs. Herbert Van Epps, 425 E. 15th St., Dover
Past-President—Mrs. A. Paul Hancuff, 3551 Maxwell Road, Toledo

AUGLAIZE

The Auglaize County Medical Auxiliary had its January meeting at Cridersville with Mrs. John Romaker as hostess. During the business meeting, Mrs. Edward Heffner, Wapakoneta, read House Bill 7225 which would amend the social security program in regard to cash payments for disability. The society voted to make a donation to the Nurses Loan Fund.

The Auxiliary members made pillow coverings for the St. Marys nursing Home following the business session.

COSHOCTON

Mrs. Robert Johnson of Coshocton was hostess to the Auxiliary of Coshocton County on January 10 with Mrs. Norman Wright, the cohostess. Mrs. William Pfaadt, vice-president, had charge of the business meeting. Dr. A. D. Juman, guest speaker, gave a talk on various aspects of dental health. Mrs. Pfaadt and Mrs. Wright were elected delegate and alternate delegate to the April meeting. Mrs. J. C. Briner displayed a group of Hummel figures which she brought recently from Germany.

CUYAHOGA

A new type of benefit hit Cleveland in January—"An Evening at Home," the project of the Woman's Auxiliary of the Academy of Medicine. It was the first in a series of activities to raise funds for the American Medical Education Foundation.

Tickets were \$1 or more, and for \$10 the title of "Relaxed Patron" was given. Letters went to 3,300 Greater Clevelanders. The need for the mailing list was the motivating force behind the Auxiliary's volunteer job of bringing the Academy of Medicine's list of doctors' home addresses up-to-date. Mrs. James N. Wychgel was the fund chairman, Mrs. Christopher Colombi, Auxiliary president, and Mrs. Charles L. Hudson, honorary fund chairman.

The Auxiliary has undertaken the sponsorship of a memorial fund to which members and friends may contribute in memory of a doctor. This fund is administered through the Auxiliary's office at the Academy of Medicine, and a card

acknowledging the donation is sent to survivors naming the donor.

There is an "Appreciation Fund," too. People who desire to express appreciation of professional interest in their health are invited to contribute to this treasury. Donations are made out to the American Medical Education Foundation Auxiliary Fund.

ERIE

Dr. Eric Kent Clarke, director of the Erie County Medical Health Guidance Center, was the program speaker at the regular monthly meeting of the Auxiliary to the Erie County Medical Society.

During the Auxiliary business meeting, reports were heard on the Christmas teas at Providence and Good Samaritan Hospitals, and the book carts offered to patients at both hospitals twice each week by Auxiliary members.

Plans were made for a "silent auction" the next meet; the proceeds to go to the National Medical Education Foundation.

Hostesses for the meeting were Mrs. D. E. Sheldon, Mrs. R. E. Hoffman, Mrs. J. C. Kromer.

FAIRFIELD

The Woman's Auxiliary to the Fairfield County Medical Society held a luncheon meeting in Hotel Lancaster, January 9. Hostesses were Mrs. M. E. Nichols and Mrs. C. G. Axline and Mrs. A. Essman.

The president, Mrs. H. M. Amstutz conducted the business session when 22 members were present.

The organization is currently sponsoring a choral group in which 20 nurses are interested.

The Public Relations committee contacted all the public schools, and beginning with the second semester, a safety program is being conducted. Each school will have a flag to fly in the hall every accident free day.

The Auxiliary members voted to establish a "memorial scholarship fund."

"Thirty-five, Midpoint of Life" is the name of the series of records prepared by the American Medical Association and sponsored by the local Medical Auxiliary, to be broadcast by the local radio station.

FRANKLIN

Mrs. John W. Dickhaut discussed "Off on a Tangent," a history of her adventures with puppets, at the January meeting of the Woman's Auxiliary to the Columbus Academy of Medicine in the Columbus Gallery of Fine Arts.

Mrs. Dickhaut discussed various kinds of puppets and their therapeutic uses for amputees, mental patients, and speech problems.

Mrs. A. L. Kefauver, president of the Auxiliary, asked Mrs. Thomas E. Fox to introduce the

speaker. Mrs. Ben Arnoff, social chairman, was in charge of the tea served after the meeting with Mrs. Elmer Groff, as chairman of hostesses.

GREENE

Excerpts from a three-act play, "The Hard Season," by Mrs. L. W. Sontag, were read by the author at a meeting of the Auxiliary to the Greene County Medical Society at the home of Mrs. Lawrence Shields on January 13. The play is based on the life of John Milton.

Twenty-one members attended the meeting at which the president, Mrs. Robert D. Hendrickson, conducted a business session. The group voted to provide a television set and toys for the pediatric ward at Greene Memorial Hospital.

HARDIN

The annual Mistletoe Ball, sponsored by the Woman's Auxiliary to the Hardin County Medical Society, netted \$900 this year, the largest sum to be made from the holiday dance since its beginning. The sum will be divided equally between Hardin Memorial and San Antonio Hospitals.

The final arrangements for the annual nurse recruitment tea at San Antonio Hospital were made.

The local response to the hospital program concerning hospital careers for both boys and girls has been splendid. Mrs. Robert Schultz was chosen as delegate to the annual state medical Auxiliary convention. Mrs. Floyd Elliott of Ada was named as alternate.

HAMILTON

The Woman's Auxiliary to the Hamilton County Medical Society met for their January meeting at Cincinnati Club. Luncheon was followed by a short business meeting conducted by Mrs. Herbert J. Brinker, president.

Guest speakers of the day, Dr. Robert C. Rothenberg and Dr. Julien E. Benjamin, were introduced by Mrs. Robert M. Woolford, program chairman. In their combined address, the physicians traced the significant relationship between medical science and religious faith in the treatment of human illness down through the ages.

KNOX

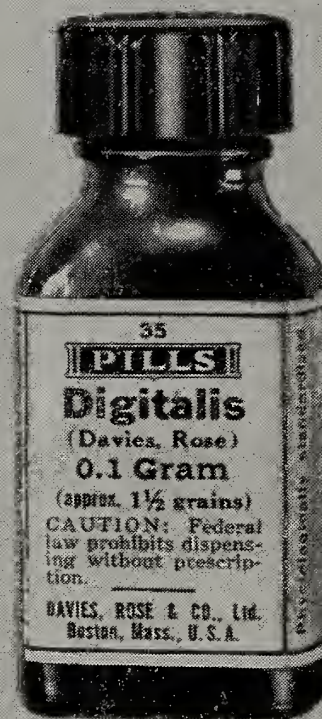
Plans to go ahead with a "golden age" group to provide social and recreational meetings for people 60 and older materialized at a meeting January 16 at the YMCA.

The first event was decided upon—a Valentine party for all residents of Mount Vernon and vicinity 60 or older. The Auxiliary of the Knox County Medical Society agreed to sponsor this first party, and provide transportation for those needing it.

The Memorial Building on January 27 was the scene of the second annual Gardenia Ball spon-

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LORAIN

Named one of the five top designers of the year, fonTayne, a young New Yorker, gave a showing of her newest creations before 200 members, guests and husbands of the Woman's Auxiliary to the Lorain County Medical Society.

Models were members of the Auxiliary, Mrs. Stewart Hawthorne, Mrs. George Hoke, Mrs. A. J. Novello, from Lorain and Elyrians, Mrs. George Bennett, Mrs. Peter Robinson, Mrs. Ray Novotney, Mrs. Earl Lance and Mrs. George Wiseman, Amherst.

Mrs. Bennett was chairman of the event and secured fonTayne who is a personal friend. Mrs. Bennett's sister, Mrs. John O'Brien, New York City, acted as commentator.

Assisting Mrs. Bennett in arranging the social affair were Mrs. Joseph Strong, Mrs. William Lord, Mrs. Stanley Birkbeck, Mrs. Peter Etzkornn, Mrs. Gordon Smith, and Mrs. Wiseman.

Oils in landscapes, seascapes and other paintings were exhibited by Donald Fay. John F. Puskas, Cleveland artist, showed a number of enamel on metal pieces.

All proceeds from the event were used by the Auxiliary for their student nurses' loan fund. The membership now has two nurses in training at M. B. Johnson School of Nursing.

LUCAS

Early in January the leadership training and public speaking group met jointly with the child development group of the Woman's Auxiliary to the Academy of Medicine of Lucas County, at the home of Mrs. Robert Taylor. Mrs. Leo Weiss and Mrs. Gerald Stark were co-hostesses. "Point of Beginning," a family life skit, was presented by the Toledo Repertoire Players.

On January 17 Professor Harold Towe, of the University of Toledo political science department, spoke at a general meeting of the Woman's Auxiliary at the academy library. A movie "Flash of Darkness" was also shown.

Luncheon was served with Mrs. O. H. Stone and Mrs. F. V. Gipson as hostesses. Mrs. Richard Hotz was chairman of the Auxiliary's health group which was hostess to the Toledo Mental Hygiene Council, Health Education Group at a meeting in the academy building on January 24.

On January 18 Dr. Joseph E. Duty, superintendent of Toledo State Hospital, lectured on mental disorders before volunteer workers at the hospital. Among the more than 80 women who attended this lecture were Mrs. Howard K. Weber, secretary of the Hospital Woman's Auxiliary, which sponsors the lectures, Mrs. William H. Bonser, a member of the mental health study group of the Woman's Auxiliary to the Academy

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of Medicine, and Mrs. James D. Gwyn, a member of the garden therapy group of the Garden Forum.

A floor show, "Convention Daze," presented by talent within the Academy of Medicine and the Auxiliary, was a feature of the group's annual dinner dance in the Crystal Room of the Commodore Perry Hotel.

Mrs. Rolland E. Scherbarth and Mrs. Ernest Sternfeld were chairmen of the dance committee.

MAHONING

Meeting for dinner the evening of January 17 in the Piccadilly Room at Tod Hotel were about 60 members of the Woman's Auxiliary to the Mahoning County Medical Society, who heard a fine talk by Mrs. James Stuhlfine, director of the Florence Crittenton Home and superintendent of nurses at the home.

Mrs. Sidney Franklin and Mrs. Stephen Ondash were chairman and co-chairman, with Mrs. F. A. Friedrich and Mrs. Frank Gelbman, chairman and co-chairman of the social committee.

MEDINA

The monthly meeting of the Medina County Medical Auxiliary was held January 17 at Hale's Alden Room, a luncheon meeting. Mrs. William Halley, president, presided and appointed a committee to arrange for a tea honoring the wives of Medina county pharmacists and dentists. This event was scheduled in Lodi February 21.

Following the business meeting, Mrs. John L. Jones of Medina, State Chairman of mental health, reported on proceedings of the recent board meeting held in Columbus.

The Medina County Medical Auxiliary of 25 members voted to give \$50.00 to the American Medical Education Foundation and \$200.00 to the state nursing scholarship fund.

MIAMI

Members of the Woman's Auxiliary of the Miami County Medical Society met for luncheon January 10 at Dettmer hospital cafeteria. Stanley Beacock, Troy librarian, talked on cook books and cookery before the business session.

OTTAWA

Woman's Auxiliary to the Ottawa County Medical Society met Thursday evening, January 12, in the home of Dr. and Mrs. Jack Witker in Lakeside. During the business session plans were begun for the annual nurses recruitment tea to be held sometime in April.

A discussion of the ticket sales for the coming Mental Health dinner to be held in St. John's Lutheran church was talked over. Doctors joined their wives later in the evening for refreshments and a social hour.

ROSS

Dinner meeting of the Woman's Auxiliary to the Ross County Academy of Medicine was held

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GYNECOLOGY—Office & Operative Gynecology, two weeks, April 16, June 18. Vaginal Approach to Pelvic Surgery, one week, April 30, June 11.

OBSTETRICS—General & Surgical Obstetrics, two weeks, May 7.

MEDICINE—Internal Medicine, two weeks, May 7. Electrocardiography & Heart Disease, two weeks basic course, July 9. Gastroscopy & Gastroenterology, two weeks, Sept. 10. Dermatology, two weeks, May 7.

RADIOLOGY—Diagnostic X-Ray, two weeks, April 30, Sept. 17. Clinical Uses of Radioisotopes, two weeks, May 7.

PEDIATRICS—Intensive Review Course, two weeks, May 14. Neurological Diseases: Cerebral Palsy, two weeks, June 18.

UROLOGY—Two-week course Oct. 8. Cystoscopy, ten days, by appointment.

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*Krantz, J. C., Jr., and Carr, C. J.: The Pharmacologic Principles of Medical Practice, ed. 3, Baltimore, The Williams and Wilkins Company, 1954, p. 998.

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January 4 at Allyn's Dining Room. Mrs. Robert P. Giesler presided at the business session.

Mrs. Lewis W. Coppel displayed safety flags which will be presented to the local schools. The flags are designed to interest school children in playground safety and will be flown below the American flag. Several schools plan to take the flag down the day following any playground accident.

Mrs. Charles N. Hoyt reported on the essay contest being sponsored by the Academy and Auxiliary. Topics in the contest for high school students are: "The Advantages of Private Medical Care" or "The Advantages of the American Free Enterprise System." Winning essays will be entered in the national contest sponsored by the National Association of American Physicians and Surgeons. Prizes to be awarded locally are: \$50, first; \$30, second; and \$20, third.

Mrs. J. C. Berno announced plans for a pre-natal clinic at Chillicothe Hospital. Mrs. Buell Ashmore reported on mental health.

A meeting of Hospital Guild followed the Auxiliary session. Mrs. William Corzine, Jr., presided and reported on the Guild Association bazaar in December, and the snack bar, sponsored by the Association, at Chillicothe Hospital. She stated \$862.62 was netted from the bazaar. Mrs. David McKell announced a profit of \$208.20 on the sale of Christmas cards.

The Auxiliary met for its February meeting at the Lynne House for luncheon. Mrs. Edward C. Jenkins of Delaware, 10th District Director of Auxiliaries to the Ohio State Medical Association, was a guest. She spoke briefly and commended the Auxiliary for its cooperation with the state organization.

Mrs. Robert P. Giesler presided at the short business session and named a nominating committee.

Mrs. Charles N. Hoyt reported on progress of the essay contest being sponsored by the Ross County Academy of Medicine and the Auxiliary.

Following the meeting a style show was presented by Helen and Mary Tudor dress shop.

SCIOTO

An "ice the cake" campaign was under way the early part of January by members of the Scioto County Medical Association Auxiliary to raise funds for the March of Dimes.

The cake was in the Columbia Theater lobby the night of January 14 with an invitation from

Manager Phil Zeller for patrons to deposit dimes in the icing. The frosting had an artistic design appropriate for the polio drive.

Members of the Auxiliary, gathered at the home of Mrs. Spencer K. Miller, were urged to insert money in the icing of a cake decorated by Mrs. George Adams. "We're doing this," said Mrs. B. U. Howland, Auxiliary president, "in an effort to stimulate other organizations also to 'ice a cake' with money for their contribution to this March of Dimes campaign."

A young polio patient, Billy De Smith, was present to assist in the drive.

A talk by Harlan Danner and election of a nominating committee were highlights of the January meeting of the Woman's Auxiliary of Scioto County Medical Association at the home of Mrs. Spencer K. Miller.

Mr. Danner, who is a member of the state committee on Civil Defense and a former Civil Defense director in Scioto County, explained the present Civil Defense set-up and emphasized the need for preparedness.

The Auxiliary voted to send another contribution to the American Medical Education Foundation.

SHELBY

Instead of holding the usual Christmas gift exchange at the December meeting, a contribution was given toward a worthy cause. *Today's Health* was entered as a gift from the Auxiliary to the Holy Angels High School, Sidney High School and Wilson Memorial Hospital.

A report of pending legislation was given by Mrs. Alice Costolo, chairman of the Legislative committee.

The meeting's program was the showing of the movie "Breast Self-Examination" loaned by the American Cancer Society. It was shown by Mrs. Russell Sinks, who gave a short lecture telling of the work that is being done in Shelby County for cancer patients and what can be done in the future.

Members of the Auxiliary devoted much of the time of their session to making cancer pads for the benefit of home cancer patients. As they worked, Mrs. H. E. Crimm presented the program by reviewing the book, *The Greer Case*. The meeting of the Auxiliary was held in the home of Mrs. Paul Crimm on Port Jefferson Road.

Unanimous approval was given to the donating of sums of money from the treasury to the na-

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tional American Medical Education Foundation Auxiliary Fund, and to the State of Ohio Nurses Loan Fund.

SUMMIT

“Little Known Facts About Our Presidents’ Wives” was Mrs. T. R. Holforthy’s topic before the Woman’s Auxiliary to the Summit County Medical Society on January 10 in the University Club.

VAN WERT

Mrs. H. D. Underwood was hostess for the February meeting of Van Wert County Medical Auxiliary at her home February 2. Mrs. E. W. Burnes reported recent medical legislative news. A movie on “Growth of Flowers” was shown.

WASHINGTON

Woman’s Auxiliary to the Washington County Medical Society met for its January meeting for dinner at the Betsey Mills Club, then adjourned to the home of Dr. and Mrs. Donald S. Williams for discussion of business.

Mrs. Don Fleming presided. Reports were given as follows: Mrs. I. J. Johnson, tax stamps chairman, announced total amount of stamps collected for the hospital; Mrs. Clarence Ash, chairman of the purchasing committee, announced equipment needed at the hospital and Mrs. Richard Hille, representative of the Eight District, reported on the meeting of the Ohio State Woman’s Auxiliary which she attended in Columbus. A contribution was made to the American Medical Education Foundation.

Creston Citizens Extend
Tribute to Dr. Boor

The Creston Lions Club recently paid tribute to Dr. S. C. Boor for his faithful and continuous service to the community by holding a celebration and dinner meeting in his honor. Dr. Boor began his practice in Creston in 1898 and has served that community since, residing for part of the time at nearby Burbank.

Dr. B. M. Foster, also of Creston, was program chairman and gave an outline of Dr. Boor’s experiences as a physician. Now 87, Dr. Boor is still in practice. Dr. Foster also presented a gift and certificate of tribute to the doctor.

Speaker for the occasion was Dr. H. T. Pease, Wadsworth, Eleventh District Councilor, who praised Dr. Boor and other physicians who practiced good medicine long before the age of modern drugs.

West Virginia Meeting

The West Virginia State Medical Association has announced that its 1956 Annual Meeting will be held at the Greenbrier, White Sulphur Springs, West Virginia, August 23-25. Details may be obtained from the Association at P. O. Box 1031, Charleston 24, W. Va.

INDEX TO ADVERTISERS

Ames Company, Inc.	346
Ann Arbor School	434
Appalachian Hall	452
Ayerst Laboratories, Inc.	433
Baker Laboratories, Inc.	455
Burroughs Wellcome & Co. (U. S. A.) Inc.	351
Ciba Pharmaceutical Products, Inc.	452
Coca-Cola Company	419
Cook County Graduate School of Medicine	444
Corn Products Sales Co. (Karo)	451
Davies, Rose & Co., Ltd.	442
Desitin Chemical Company	450
Endo Products, Inc.	454
Geigy Pharmaceuticals, Inc.	415
Harding Sanitarium	354
Hoffmann-LaRoche, Inc.	Insert between pages 436 - 437
Knox, Chas. B., Gelatine Co., Inc.	403
Lakeside Laboratories, Inc.	341, 434, 444
Lederle Laboratories	398-399, 440
Len-A-Pe Village	438
Liebel-Flarsheim Co.	347
Lilly, Eli, and Company	364
Loma Linda Food Company	363
Luzier's, Inc.	446
MacAllister Laboratory	440
Magnetic Springs Foundation	356
Mallard, Inc.	438
Manitowaning Lodge	436
McMillen Sanitarium	354
Mead Johnson & Company	Back Cover
Medfoam Products Co.	436
Medical Protective Company	443
New York Polyclinic Medical School	417
Parke, Davis & Company	456 and Inside Back Cover
Pfizer, Chas. & Co., Inc.	343, 355
Resthaven	356
Riker Laboratories, Inc.	345
Rocky Glen Sanatorium	356
Sanborn Company	453
Sawyer Sanatorium	360
Schering Corporation	427 and Insert Between Pages 452 - 453
Scroggins, Clayton L., Associates (Medical-Dental Management)	449
Searle, G. D. & Company	409
Sharp & Dohme, Inc.	348-349, 357, 421, 439
Smith, Kline & French Laboratories	423
Squibb, E. R. & Sons, Division of Olin- Mathieson Chemical Corporation	362
Stoneman Press	449
Tutag, S. J. & Company	419
Upjohn Company	353, 417
U. S. Vitamin Corporation	358 - 359
Vitamin Food Co., Inc.	437
Wallace Laboratories	361
Wendt-Bristol Company	443
Wesnoca	440
Wickhaven Sanitarium	435
Windsor Hospital, Inc.	448
Winthrop Laboratories	425
Wyeth, Inc.	407, 445

Classified Advertisements

Rates: 50 cents per line. Minimum charge of \$1.00 for each insertion. Price covers the cost of remailing answers. Forms close 15th of the month preceding publication. To assure prompt delivery, when replying to an advertisement over a *Journal* box number, address letter as follows: Box (insert number), c/o The Ohio State Medical Journal, 79 E. State St., Columbus 15, Ohio.

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MEDICAL AND DENTAL OFFICES available in a new ten-unit all airconditioned medical building. Contact A. W. Brownstone, M. D., Painesville, Ohio.

WANTED: Physician, competent for industrial office. Excellent opportunity. 200 Republic Bldg., Cleveland, Ohio.

INTERNIST, 4 yrs. training as resident in medicine; age 32; married and 3 children; desires position in clinic or desirable location with group or another doctor where he can practice internal medicine. Box 860, c/o Ohio State Medical Journal.

ANESTHESIOLOGIST: Young doctor completing residency in June seeks location in Ohio. Box 861, c/o Ohio State Medical Journal.

WANTED: Physician for locum tenens in an industrial office during April or May, or any portions of those months. 200 Republic Building, Cleveland, Ohio.

OBSTETRICS-GYNECOLOGY PHYSICIAN, Board eligible, desires association with Ob-Gyn physician or medical group. Box 859, c/o Ohio State Medical Journal.

FOR SALE: Near Cleveland; Excellent well-established general practice grossing \$38,500 in 1955; well-equipped office; modern, open-staffed hospital nearby; Easy terms; will introduce; Available July 1, 1956; leaving to specialize. Box 864, c/o Ohio State Medical Journal.

WOULD LIKE TO ASSOCIATE with older GP or internist who wishes to retire in a year or two—to start practice in Internal Medicine. Event. possibility to buy later his practice. I am graduate from Vienna Medical School, have Ohio license, 45 yrs. old, completing in May 2-yr. residency in Medicine. Box 873, c/o Ohio State Medical Journal.

WANTED: Full-time physician as Assistant Medical Examiner in Cincinnati, Ohio, for large railroad. Must be in good health, under 55 years of age, and graduate of Class A American School. Starting salary \$750.00 per month with rapid advancement. Box 872, c/o Ohio State Medical Journal.

BARGAIN, MEDICAL OFFICE EQUIPMENT, General Practice, all or part, private party. Cincinnati area. Box 871, c/o Ohio State Medical Journal.

PHYSICIAN with Ohio license desires position as an assistant in busy office or house physician in general hospital. Has excellent training in Obstetrics, Gynecology and Surgery. Box 875, c/o Ohio State Medical Journal.

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GENERAL PRACTITIONER, many years hospital experience in dermatology, pediatrics and psychiatry, own private practice, desires association or assistantship or position in industrial or insurance medicine. Larger city preferred. Box 869, c/o Ohio State Medical Journal.

EXPERIENCED RADIOLOGIST, Board Member, seeks association with a Hospital or Group. Will establish X-Ray Laboratory in area not covered by a Radiologist. Ralph E. Herendeen, M. D., 30 East 40th Street, New York 16, N. Y.

OTOLARYNGOLOGIST, Board qualified and University trained; also experienced in Ophthalmology; available July 1st; desires location or association. Box 866, c/o Ohio State Medical Journal.

FOR SALE: Beck Lee Electrocardiograph (Cardi-all). Used; two years old; excellent condition; no repair needed. John F. Harley, M. D., 145 West High Street, Springfield, O.

FOR SALE: Sklar suction-pressure pump with tonsil attachments, \$15. Cameron unit in carrying case complete with cautery-fulguration, proctoscopic attachments with light and inflation bulb; 3 diagnostic lamps; head light; mouth gap with self retaining tongue depressor. A real bargain at \$45. R. P. Bogniard, M. D., 404 Samaritan Ave., Ashland, O.

PHYSICIAN age 45 with Ohio license, 10 years experience in anesthesia including anesthesia in brain and chest surgery, desires position in private or community hospital with salary \$800 or fee basis. Box 874, c/o Ohio State Medical Journal.

FOR SALE: Doctor's house and office combined. No drugs or equipment. Town of 850 in Central Ohio with exceptionally large drawing area. One doctor in town. Leaving state. Box 876, c/o The Ohio State Medical Journal.

Creston—A branch of the Lodi Community Hospital held a buffet dinner and community gathering in honor of Dr. B. M. Foster for his 25 years of service to the Lodi Hospital and the surrounding community.



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The Physician's Bookshelf

By JONATHAN FORMAN, M.D.

Black Market, Gray Market, and Legal Placement in The Adoption of Children

FTEN a physician is called upon to give advice to a childless couple or to a couple who cannot have any more children and feel that their only child needs another youngster to grow up with. Most of us are not informed on the details of child adoption and so our advice is bound to be inadequate to say the least.

What do we know about the pitfalls that beset a couple when they begin to look around for a baby to make their own? Precious little, I am sure, about the bureaucratic deadends, the legal impediments, the heartaches and the anxieties that come from not knowing what lies ahead once the couple has announced their intentions to take themselves a baby to raise as their very own.

What is wrong with buying a baby from the black market and thereby getting action without delay? They get the baby they want, don't they? The homeless baby gets a home and parents, doesn't it? Well what's wrong with that? Or the "gray market," what's wrong about that? You ask a doctor you know to find you one and he does. Are there any dangers in such a simple procedure? It costs about the same as having one of their own, so what is wrong about that?

These are some of the questions about which you and I are seldom prepared to advise our patients or friends. Ernest and Frances Cady have just written a book which we physicians would do well to place in the hands of inquiring couples rather than to attempt to advise them ourselves. The Cadys live in Columbus where he is an editorial writer and book editor on *The Columbus Dispatch* and she is director of The Ohio Children's Society as well as chairman of the Franklin County Child Welfare Board.

The book is entitled *How To Adopt a Child*, and is published by *William Morrow & Co., New York* (\$3.00).

In 1952, Mr. Cady wrote the biographical story of the Cady's family life entitled *We Adopted Three*, published by Sloane and republished in England. In addition to their personal experiences in child adoption, the Cadys have maintained a long interest and participation in child welfare work. Mr. Cady along with the reviewer was one of the incorporators of The Ohio Children's Society and has continued to serve on its Board and act as its secretary.

To inform the prospective adoptive parents about all the details of adoption the Cadys have written a manual designed to serve as a complete guidebook for anyone who wants to know all of the facts about adoption. The book is divided into two parts: *The Road to Adoption*, and *Now That You've Adopted*.

The book begins with a soul-searching chapter on why do you want to adopt? This is followed by a chapter on where to obtain a baby. It may be through authorized public or private agencies. Here in Ohio, we have 60 county child welfare boards which are public agencies authorized by the State Board of Public Welfare to make pre-adoptive placements. In addition to these public agencies, there are 32 private agencies scattered through the larger cities representing the Catholic Charities, the Jewish Family Service, Protestant denominations and other groups. The Cadys describe what the agency expects of the prospective parent and what the prospect may expect of the agency. In short there is or should be a sincere effort at matching. This means in matters not only of religious background of the mother but also of race, temperament, ethnic consideration and in every way that will make the child compatible with his home as he grows up and to the end that he will look like and act like he belongs to his family.

Careful physical examinations are made so that the adopting parents will not run even as much risk as they would in having their own children. Parents are assured that they shall have a healthy child with normal mentality.

THE GRAY MARKET

This is the popular term for the more accurate one of "independent placements." In the black market the operator is a criminal operating just for money. "Some gray operations are almost as deep-dyed as the black market variety. But at the other end there are some, though relatively few, perhaps, that might be called no more than off-white." As a rule they represent an effort on the part of someone to help someone—the unwed mother, the adoptive parents or the child itself.

It has been estimated that there are about 5,000 adoptions per year in Ohio. For every child available for adoption, there are probably 10 couples—and some workers in child welfare put

the figure at 15 or more—seeking a child for adoption. This means couples who seriously want to adopt and who are eligible to do so. Such a one-sided picture obviously has its implications for gray market dealings.

In 1954 in Massachusetts 1,500 out of 2,000 adoptions were transacted without legal sanction. In Franklin County, Ohio, adoption decrees resulting from agency placements accounted for less than 50 per cent of all those issued during 1953.

This chapter should be read by every physician so he may see what risks he runs in attempting to help people rather than referring them to a responsible agency which makes a matched as well as a legal placement.

Physicians whose appetites are whetted for more information on this subject after they have read this interesting book may wish to write to the Children's Services of the Division of Social Administration, Department of Public Welfare, Oak Street at Ninth, in Columbus. This state agency administers adoption regulations on the state level and issues certification to local adoption agencies. Statutes pertaining to child welfare may be found in the Ohio Revised Code, Sections 5103.01 to 5103.99, inclusive. Section 5103.16 has to do specifically with the placing of a child under 2 years of age.

A unique feature of the book is its complete list of all adopting agencies in all of the 48 states. Such a list has not been available heretofore. Another feature is the section entirely devoted to parents who have already adopted a child—helpful, commonsense advice on everything from what to tell the child to the question of environment vs. heredity.

Certainly, this is a manual which every physician should have to answer questions about adoption.

The Management of Oral Disease, by Joseph L. Bernier, D. D. S., (\$15.00. *The C. V. Mosby Company, St. Louis 3, Mo.*). This is a treatise on the development, recognition, and treatment of disease in the oral region, with 101 text illustrations and five plates in color, along with a comprehensive text of 800 pages.

A Handbook of Hospital Psychiatry, by Louis Linn, M. D., (\$10.00. *International University Press, New York 11, N. Y.*). This practical guide to psychiatric therapy, written by the attending psychologist of Mt. Sinai Hospital of New York City, represents another approach to the teaching and practice of this branch of medicine. It is presented in a practical way, setting forth the daily needs of the staff of a mental hospital, and suggesting answers to their problems. The author does not single out one therapeutic approach, but tries to diagnose all the conditions which affect the patient in a mental hospital.

Development Concordance and Discordance During Puberty and Early Adolescence, by Douglas M. More, (\$3.00. *Child Development Publications, Champaign, Ill.*). This study delineates the relation between physical, emotional and social development in adolescence and undertakes the integration of the material gathered on 17 girls and 16 boys living in a typical mid-western community during the seven years when they contributed to a research study on human development. It is an investigation of the development of character and personality during late childhood and adolescence. Personality here means the "determinant of behavior." This report is a part of that larger research.

Fifty Years a Surgeon, by Robert T. Morris, M. D., (\$0.35. Signet Key Book, published by the *New American Library, New York 22, N. Y.*). This autobiography of a great surgeon whose memory has lived in the "Morris Appendix," is said to have influenced Morton Thompson in depicting the medical incidents in his novel *Not as a Stranger*.

Year Book of Medicine, 1955-1956 Series, (\$6.00. *Year Book Publishers, Chicago 11, Ill.*). This book remains a "must" in the library of every physician who wants to review the medical progress of the last 12 months.

The Science Book of the Human Body, by Edith E. Sproul, M. D. Illustrations by Kathleen Elgin, (\$0.35. *Pocket Books, Inc., Rockefeller Center, New York 20, N. Y.*). This is a clear and up-to-date presentation of human anatomy, which explains all of the organs of the body and how they work, and how they are related. It is a very nice text as an introduction for such instruction as the physician may wish to give his patient.

Sex in History, by G. Rattray Taylor, (\$5.00. *The Vanguard Press, Inc., New York 17, N. Y.*) The author believes that the story of how Man has handled his sexual drives is also the story of how he has handled all of his creative impulses. His attitudes to these imperatives have colored his whole scheme—his politics, art and religion. This is a pioneer study, tracing and evaluating society's changing attitudes towards sex.

Society and Medicine, edited by Iago Galdston, M. D., (\$3.00. *International University Press, New York 11, N. Y.*). This little volume contains the 17th series of lectures to the laity presented by The New York Academy of Medicine. These essays range in subject matter and in divergence of approach to both society and medicine—the different aspects which society and medicine present to the inquiring intelligence and afford the reader a fine perspective on the inter-relationships operating between society and medicine. Disease and its setting are discussed by the distinguished professor of child health from England, Sir James Spence; Biology of Ethics, by

Dr. Gerard, Professor of Physiology of The University of Chicago; *The Natural History of Neurotic Behavior*, by Howard S. Liddell, Professor of Psychobiology at Cornell; *Environment and Heredity*, by Theodore Ingalls of the School of Public Health at Harvard; *Changing Concepts of Child Care*, by Milton Senn, Professor of Pediatrics and Psychology at Yale; *Environment and Nutrition*, by Russell Wilder of The National Institutes of Health. This Series is authoritative in quality, informative in substance, and provocative and inspiring in effect.

The Practice of Mental Nursing, by May Houston, (\$2.75. *Williams and Wilkins, Baltimore 2, Maryland*). This book is written for junior nurses in mental hospitals, but is equally useful for any nurses dealing with neurotic and psychotic patients.

Systemic Associations and Treatment of Skin Diseases, by Kurt Wiener, M. D., (\$17.00. *The C. V. Mosby Company, St. Louis 3, Mo.*). In distinction to the study of skin manifestations of internal disorders, the present volume is concerned with the relationship of dermatology and general medicine. Lupus erythematosus, scleroderma, dermatomyositis, erythema exudativum multiforme, erythema nodosum, acne, rosacea, atopic eczema, contact eczema, dermatitis exfoliativa, urticaria pruritus, psoriasis, parapsoriasis lichenplanus, pemphigus vulgaris, dermatitis herpetiformis, herpes zoster, acanthosis nigricans, light dermatosis, porphyria, lipodosis polyderma, disease of the sweat apparatus, pruritus and keratosis, hair disease, vitiligo, are all discussed. The second part of the book deals with the systemic treatment of skin diseases.

The Mayo Clinic, by Lucy Wilder, (\$3.75. 2nd Edition. *Charles C. Thomas, Publisher, Springfield, Ill.*). Written by the wife of the leading physician of medicine of the Foundation where her two sons have done their postgraduate work, the past, present, and blueprints for the future of the Clinic and Foundation are all presented here. This edition includes the extensive expansion of facilities which has taken place in the Clinic.

Emotional Problems, and What You Can Do About Them, by William B. Terhune, M. D., (\$3.00. *William Morrow & Company, 425 Fourth Ave., New York 16, N. Y.*). This is another book of common sense advice based upon 35 years of successful practice as a psychologist. It is offered as a First Aid to wiser living.

I Cured My Cancer, by Mary Payne, R. T., (\$2.50. *The Vantage Press, New York 1, N. Y.*). This technician describes how now, after being condemned to death by cancer 14 years ago, she is devoting her time and skill in x-ray therapy for others. This is designed to help others combat the horrors of the disease from which she has recovered.

Thresholds to Professional Nursing Practice, by Frances M. McKenna, R. N., (\$4.25. *W. B. Saunders Company, Philadelphia 5, Pa.*). This book is designed primarily to bridge the span of time which extends from the undetermined moment in the student's senior year until she has established herself as an independent professional worker. It clarifies relationships and points up the influences of tradition, current practice, and other matters not usually discussed in the nursing curriculum.

Fluoridation as a Public Health Measure, edited by James H. Shaw, (\$4.50. Publication of *The American Association for the Advancement of Science, Washington 5, D. C.*). This is the third monograph to be published by the Association on the subject. It is a reasonably complete evaluation of our present knowledge, presented in a most enthusiastic manner, and in your reviewer's opinion, overstating the case. In our present-day culture, where we get regularly our daily poisons, possibly one more does not make any difference.

Advances in Experimental Caries Research. Edited by R. E. Sognnaes, (\$6.75, a publication of *The American Association for the Advancement of Science, Washington 5, D. C.*). This is the first volume devoted specifically to information that has been gathered from experimental research in this subject. Twenty distinguished investigators have made their contributions. Strangely enough, we have become so accustomed to people losing their teeth through decay that the problems of dental caries have little emotional appeal to our people. This whole subject needs to be investigated as the costliest disease in time and money with which we are confronted in this country.

Back Roads and Bicarbonate: The Autobiography of an Arkansas Country Doctor, by E. H. Abington, M. D., (\$2.75. *Vantage Press, New York 1, N. Y.*). From cotton plantations just after the end of slavery, to horseback riding, to horse and buggy—all the surprising experiences, medical and otherwise, of the author's career as a doctor, druggist, and banker, are here told without literary pretensions, in a most interesting way. It is good reading.

Genetics and Metabolism, by Robert P. Wagner, M. D., and Herschel K. Mitchell, M. D., (\$7.50. *John Wiley & Sons, Inc., New York 16, New York*). This book brings together a variety of facts and ideas derived from the fields of genetics and biochemistry, and, to a lesser extent, from physiology, cytology, and embryology, in an attempt to synthesize a general picture of the biochemical basis of inheritance. It bears the thesis that inheritance is characterizable in terms of transmission of control of relative rates of biochemical reactions within the complex and interlocked metabolic patterns.

The Ohio State Medical Journal

Published under the direction of The Council for and by the members of The Ohio State Medical Association, a scientific society, non-profit corporation, with a definite membership, for scientific and educational purposes.

Vol. 52

May, 1956

No. 5

JONATHAN FORMAN, M. D., *Editor*

CHARLES S. NELSON,
Managing Editor—Bus. Mgr.

R. GORDON MOORE,
Asst. Managing Editor

The Use of Succinylcholine Chloride In Electroshock Treatment

ROBERT W. BUCKLEY, M. D., and WARREN L. RICHARDS, M. D.

THE chief physical hazard in electroshock therapy is compression fracture of the thoracic spine, though other fractures and cardiovascular dangers must be reckoned with. For example, Dewald et al.² reported 20.8 per cent vertebral fractures, diagnosed by x-ray, in 263 patients receiving electroshock treatment. The hazards stem mainly, not from the application of electricity itself, but from the grand-mal convulsion; in general, only electrical apparatus capable of producing unconsciousness and typical convulsion can regularly give good treatment results in affective disorders.

Numerous attempts have been made, by the auxiliary use of drugs, to "soften" or eliminate the convulsion, and thus decrease physical risk. Pentothal® sodium, amytal® sodium, and surital® sodium, while primarily directed toward producing amnesia and allaying anxiety, have shown some effect in decreasing the force of the muscular convulsion. Drugs directed more specifically at muscular activity have included curare, flaxedil®, and decamethonium compounds. All have disadvantages, either in prolonged or profound action, effects on blood pressure and laryngeal tone, or the added complication of using potent antidotes such as prostigmin® or tensilon®.

In 1949, Bovet et al. discovered the short curare-like effect of succinylcholine iodide. In 1951, Low and Tammelin produced the compound in pure crystalline form, eliminating some toxic circulatory effects. Since then, many reports^{1, 4, 5, 6} have described succinylcholine as a

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rapid and safe muscle relaxant in electroshock therapy. The drug has been recommended as a routine for all electroshock therapy, but with this we cannot entirely agree, as will be discussed later.

PHARMACOLOGY

Succinylcholine produces neuromuscular block by depolarization of the muscle end-plates and the surrounding muscle fibers. The effect is similar to that of acetylcholine, and is probably due to inhibition of cholinesterase. First fascicular muscle twitching, then relaxation follows, as the muscle cannot respond until the succinylcholine is broken down into succinic acid and choline, presumably by a "pseudo"-cholinesterase in the blood serum.³ Prostigmin® and tensilon® must not be used, as they also inhibit "true" cholinesterase at the neuromuscular junction and thus prolong paralysis due to succinylcholine. Har-

Presented before the annual meeting of the Ohio Psychiatric Association, at Cincinnati, April 20, 1955.

per, among other clinical observations, noted a case where neostigmin (prostigmin®) was given in addition to succinylcholine and the patient did not recover for three hours.

At another pharmacological level, quite important clinically, reports by Wilson, Nowill and their associates indicate that levels of oxygen consumption and carbon dioxide accumulation in electroshock treatment modified by pentothal® and succinylcholine are comparable to those at rest, and much lower than those with other electroshock treatments not using muscle relaxants, and that if atropine, pentothal®, and succinylcholine are used in adequate dosage, the incidence of hypertension and arrhythmias following electroshock is lower than with no drugs at all.

PROCEDURE

Recommendations in the literature as to administration have been varied. We have been surprised by some of the small doses recommended⁵ and the rather equivocal statements in some papers about the use of artificial respiration. It appears that the goal, when using small doses of succinylcholine, has been to produce softening of the convulsion without marked respiratory effects. This has not been particularly our aim: we have tried to produce a deep, though brief, muscle relaxation with temporary apnea, and we regard the provision of controlled respiration as an essential part of the procedure.

Following a brief period of experimentation, our procedure has become quite standardized.* The patient is fasted from the night before. One hour before treatment, atropine sulfate 0.8 mg. is given intramuscularly. The patient is treated in an ordinary hospital bed, without pillows, sandbags, or other positioning devices. Laid out nearby are a Guedel rubber airway, a laryngoscope, and a Murphy endotracheal tube. An oxygen tank with conventional reducing valve, and fitted with an apparatus consisting of Heidbrink face mask of appropriate size, Heidbrink face inhaler casting, T-tube and 3-liter rebreathing bag, is kept at the head of the bed. Minimum personnel comprises the operator and one nurse-assistant.

While lying supine, the patient is given pentothal® sodium 250 mg. intravenously; occasionally slightly larger or smaller doses are found more suitable. As the patient rapidly becomes disoriented and drowsy, the nurse hands the operator a syringe containing succinylcholine chloride** 40 mg. in 2 cc.; here again, the dosage has varied slightly, with lower and upper limits of 30 and 60 mg. respectively. While the nurse

affixes the headband and electrodes of the Medcraft B-24 electroshock apparatus,† the succinylcholine is rapidly injected through the original needle. (We have not mixed pentothal® and succinylcholine in the same syringe as recommended by some because of the tendency of succinylcholine to decompose in alkaline solution.) The operator then stands by with the oxygen apparatus and observes the period of generalized fascicular twitching, which usually begins within 30 seconds, and terminates in profound muscular relaxation with apnea. An average of 4 or 5 forced inhalations of pure oxygen is given by manual pressure on the rebreathing bag. By this time, approximately two minutes have elapsed since administration of the succinylcholine, and the patient is well relaxed but thoroughly oxygenated.

At this point, conventional electroshock is given. The patient shows a momentary slight spasm, sometimes restricted to the face and sometimes perceptible in the extremities, followed again by apparent relaxation. Within 3 to 5 seconds, various convulsive equivalents appear: the most regular in our experience has been a piloerector response followed shortly by vasodilatation and flushing of the face. There is virtually no muscular movement during the several seconds which represent the tonic phase of the seizure, though blepharospasm and weak contraction of the muscles of the hands, feet, and abdomen may be observed. There are usually some mild clonic contractions of the extremities during the latter 10 to 30 seconds of the 45-second period; these have been found to be a useful end-point to gauge the duration of the fit.

Some practice and observation of the foregoing signs is necessary to distinguish between lack of response due to inadequate electrical dosage, and the pattern of the markedly inhibited seizure. In the case of the former, another stimulation at higher dosage is given immediately, to produce a characteristic response. No restraint is used; in cases where patients have incomplete or irregular teeth, a tongue blade or the tip of an airway is inserted between the teeth just prior to the initial shock.

As soon as the slight clonic manifestations cease, the oxygen mask is reapplied, and artificial respiration is again begun. The patient makes respiratory efforts within two minutes after the treatment, usually beginning with abdominal expiratory effort, and with variable speed adding diaphragmatic contractions; these are aided by gentle manipulation of the rebreathing bag. As soon as spontaneous respiration is reestablished—usually less than 3 minutes—the patient is turned on his side, where return of muscular activity proceeds rapidly.

Most patients awaken quietly within 15 or 20

*Our first treatments were given with the assistance of anesthesiologists. For this help, and for many suggestions and contributions to technique, we are indebted to Dr. Lloyd Larrick and associates. Valuable help in obtaining apparatus and perfecting technique was also given by Miss Virginia Hamilton, R. N.

**In this series, the main preparation used has been anectine® (Burroughs-Wellcome).

†The Medcraft apparatus has been used almost exclusively, though other electroshock machines could be used equally well. Our average dosage has been 120 to 130 volts for 0.6 to 0.75 seconds.

minutes, showing characteristic amnesia and temporary confusion. During the procedure itself and afterward, the rubber airway is inserted only in the minority of cases where obesity, edentulism, or other individual anatomical features cause functional obstruction. Although apparatus is kept always on hand for tracheal intubation, no case of laryngospasm has yet been encountered; this is presumably because of the powerful relaxant effect of the succinylcholine on the laryngeal musculature.

MATERIAL

This technique has been applied, during the two years ending March 31, 1955, to 27 patients receiving a total of 195 electroshock treatments. Of the series reported, we feel 11 patients would have been physically disqualified for convulsive electroshock treatment. We are now using it routinely in patients requiring electroshock. Five cases illustrating common problems are presented briefly:

CASE REPORTS

Case 1. A 45 year old, active and unusually muscular white man was started on electroshock treatment with pentothal® on March 18, 1953, because of an endogenous depression. With the first three treatments, he developed increasingly severe mid-thoracic back pain; roentgenogram showed compression fracture of the fifth thoracic vertebral body. With administration of succinylcholine by intravenous drip to a total of 100 mg., and pentothal® sodium up to 1500 mg. to control twitching and restlessness, he was given a fourth electroshock treatment. There was marked inhibition of the convulsion, but cyanosis and relatively prolonged apnea required oxygen insufflation for 5 minutes after the treatment. The remaining three treatments were given with 50 mg. of succinylcholine in a single injection, with oxygen insufflation before and after the electric shock; in this way, smaller doses of pentothal® were adequate, there was no cyanosis, and respiratory movements were resumed within 2 minutes.

Patient improved rapidly and was discharged April 28, 1953. He reported himself free of back pain within 2 or 3 weeks.

Case 2. A 76 year old, small and frail white widow, with a blood pressure of 170/100 and generalized osteoporosis, had previously received courses of electroshock, with and without curare, by other psychiatrists in 1946 and 1947 for recurrent agitated depression. When first seen by one of us (RWB) in 1951, she responded well to a course of Medcraft treatments combined with continuous stimulation for 5 to 6 minutes with the Reiter apparatus.

On March 21, 1953, the patient was readmitted to the hospital. Although she could voice few specific complaints because of depression and agitation, she was found to have marked osteoporosis and a fresh compression fracture of the second lumbar vertebra, presumably sustained in a fall at a rest home a few days previously. Prolonged hospitalization with medication and psychotherapy produced no significant improvement.

On June 19, 1953, she was started on electroshock modified by succinylcholine. She had no untoward reactions and improved markedly within five treatments, although still kept on bed rest upon the recommendation of an orthopedic

consultant. She again relapsed into depression in October 1954, was given nine treatments with succinylcholine as a hospital patient with good results, and has since been carried on a "maintenance" program of outpatient electroshock at 6 to 8 week intervals.

Case 3. A 42 year old white man developed severe agitated depression during medical treatment following a coronary occlusion, associated with previous hypertension, in May 1954. He was given six electroshock treatments with the technique described, beginning in August 1954, and resulting in complete clinical remission. Serial electrocardiograms during the entire course of treatment showed no change, even immediately following individual treatments.

Case 4. A 35 year old white married woman developed severe neurotic depression in a setting of hysterical neurotic character, made numerous suicidal gestures, and finally eviscerated from a recent cholecystectomy wound, probably due to her own self-destructive efforts. She was given three electroshock treatments with succinylcholine, while the wound was still being surgically drained, but refused further treatment and signed out against advice. Later reports from the family physician indicated that wound healing was not delayed.

Case 5.* A 78 year old white retired business man was hospitalized because of agitated depression; electroshock was at first felt to be contraindicated because of long-standing hypertension, incipient cardiac failure sometimes requiring digitalis, frequent anginal attacks, and a frightening episode during a previous attempt at electroshock therapy when he developed auricular fibrillation and myocardial insufficiency. He was given a total of 10 electroshock treatments with succinylcholine, and improved markedly without evidence of untoward physical reaction.

DISCUSSION

In this series, routine roentgenographic studies of the spine have not been done, although such studies have been reported by Dewald et al.² in treatments using syncurine.® None of our patients have complained of back pain following treatment, although three noted a mild feeling of tension in the neck and jaws; this has also been noted by Murray. Although cyanosis followed by hyperpnea is a regular feature of unmodified electroshock treatment, all outpatients have remained "pink" throughout the procedure, and resumed breathing in an easy and unlabored fashion, except in Case 1, where a large dose of succinylcholine was given and oxygen was not used before treatment.

Pulse increases have been very moderate during the treatment itself, the highest being from 90 to 140 per minute in Case 5; here, the rate dropped to resting level within 2 or 3 minutes. There have been no instances of significantly prolonged apnea in our cases. No deaths have occurred which were felt attributable to treatment; the one death reported was due to cerebrovascular accident in a 68 year old woman who

*We thank Dr. Alvin L. Dunbar for permission to cite this case, which he kindly referred for treatment.

was well for five months following her series of five treatments.

Treatment results appear to compare exactly with those of unmodified electroshock treatment; since this was not the focus of our study, however, no control series was conducted. It should be added, perhaps as a "dynamically oriented" observation, that our most enthusiastic observers who found some decrease in postshock confusion, more rapid relief of agitation, etc., were not taking into account the effect of the physicians' enthusiasm about any new treatment on the response of the first few patients. The main dangers of this, of course, lie in the temporary relief liable to be obtained, and in the unfortunate misunderstanding by the physician of exactly what he has done to get his patient well.

Some of our colleagues have been taken aback by the apparatus and attention required. The fact is that this technique, properly applied, demands some understanding of the mechanics of respiration, some practice in the proper fitting of a face mask and the manipulation of a re-breathing bag, and awareness of the indications for insertion of an airway. We do not feel the latter should be done routinely, for fear of inducing laryngospasm by means of pharyngeal reflexes. In addition, although we have yet to encounter a significant degree of laryngospasm, we regard it as mandatory to have apparatus available for tracheal intubation—and to be practiced in its use—in case laryngospasm should develop.

As can be gathered from these observations, we feel that the technique described shifts emphasis to the maintenance of controlled respiration in an unconscious and relaxed patient for 2 to 4 minutes—essentially a brief exercise in anesthesiology. Wilson and Nowill⁶ call attention to this fact—in their series of 1045 treatments they had only three untoward incidents—all traceable to defects in anesthetic technique. The advantages of the treatment make it desirable for all patients requiring electroshock treatment, but no physician should undertake it without both understanding and supervised experience in anesthetic technique. Any psychiatrist unable or unwilling to adopt this orientation should secure the services of an anesthesiologist for each treatment.

SUMMARY

The technique of modification of electroshock therapy by intravenous pentothal® and succinylcholine is described, and 27 cases are reported in which it has been used, including 11 in which it is felt that physical handicaps of the patient would otherwise have contraindicated electroshock treatment. The procedure is recommended for general use, as prophylaxis against skeletal and other damages from electroshock, but it should not be attempted by anyone not prepared to deal

with the problems of controlled respiration in an unconscious and paralyzed patient.

Addendum (3-10-56): Since the time of this report, the authors have applied the same technique to 18 additional patients for a total of 122 treatments, with essentially the same results and findings.

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Vasomotor Rhinitis In Hypertension

Very recently a whole new group of cases have been seen as a result of the use of the newer anti-pressor drugs in the treatment of hypertension. It has been recognized for many years that an occasional severe hypertensive patient will exhibit vasomotor rhinitis as a concomitant reaction to the disease.

The older vasodilator drugs (such as the nitrites) did not seem to affect the nasal tissues and, if turgescence were present before treatment with them, it was soon relieved as the blood pressure was reduced. On the other hand, reserpine, rauwolfia and the sympathetic-blocking agents which are now being widely prescribed, apparently have a non-selective action on all vascular smooth muscle and cause very annoying, even distressing, nasal congestion in a large percentage of the patients employing them.

This form of vasomotor rhinitis is apparently not being recognized as yet, as so very many patients seek otolaryngologic aid for "a head cold which won't clear up." The history often reveals especial difficulty with breathing at nights, with loss of sleep, secondary emotional distress and increasing hypertension in spite of the drugs.—Samuel L. Fox, M. D., Baltimore: *Maryland State M. J.*, 5:144, March, 1956.

The Problem of Alcoholism

The emphasis in psychiatry is on elimination of the anxieties leading to alcoholism; in Alcoholics Anonymous the emphasis is on the strength to bear these anxieties.—Max Hayman, M. D., Beverly Hills: *California Medicine*, 83:435, December, 1955.

Plastic Operations of the Fallopian Tube

SAMUEL L. VINCI, M. D.

THE incidence of occluded fallopian tubes being the cause of infertility is relatively common. The defeatist attitude assumed by most authors reporting on this subject has done much to cause most operators to consider the tubal plastic operation hopeless and unpopular. It is our humble opinion that now with the newer antibiotics, better anesthesia, and much improved pre- and postoperative care we should and will get much better results with the operation of tubal plastic.

In presenting these four cases we are making a plea for more conservative treatment in the surgical approach to these cases. We are also hoping that more operators will attempt these operations and thus even better the salvage rate on this type of infertility which seems to occur more frequently in the younger group of women in the reproductive periods of life. In approaching this problem we are using many of the old techniques plus a few possibly newer ones which we feel are most helpful.

The occluded fallopian tube is opened longitudinally and a new ostium formed by everting the mucosa of the fallopian canal and suturing it to its serosa using very fine interrupted intestinal sutures. These tubes are then very thoroughly insufflated with normal saline which is gently pushed through the tube with a 10 cc. syringe and an attached flexible hollow sound.

When the occlusion is in the isthmus, a new opening may be forced into the uterus and the new ostium kept open by inserting several strands of chromic catgut from the tube into the uterus thus creating a communicating fistula. Then we have found it most helpful to plicate the ovarian ligaments using a nonabsorbable suture. This procedure applies the ovary closer to the ostium in the tube and keeps the adnexa from becoming adherent in the cul-de-sac. This can further be aided by plicating the uterosacral ligaments which also gives the uterus much better support.

We have found that a modified type of Crossen uterine suspension lends a lot of success to this procedure. This type of uterine suspension has allowed the uterus to remain in good position even after two or three pregnancies.

CASE REPORTS

Case 1. Mrs. —, 26 years old, married 6 years. The patient had attempted to become pregnant for five years without any success. The attending physician put the patient through the routine office infertility studies consisting of: First, a thorough history and physical examination and

Submitted January 20, 1955.

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complete sperm study on the husband, all of which were normal. Second, a complete history and physical examination on the wife which brought out the following findings: A three month rectal temperature chart showed that the patient ovulated each month about 14 days before the beginning of her menstrual period.

The physical examination was essentially negative except for an incisional hernia over a right McBurney scar and the pelvic examination showed the uterus fixed in retroflexion and large bilateral adnexal masses typical of chronic pelvic inflammatory disease. The cervix was grossly normal except for a slight internal os stenosis. Third, a Huhner test was performed, and it was found that there was an adequate number of normal appearing and movable sperm in the patient's cervix.

On the basis of these studies the patient was first admitted to Doctors Hospital on May 1, 1949, for further diagnostic studies as to the cause of her infertility. Patient is of the white race and she was in no distress at the time. The history of the case revealed that the menarche occurred at 12 years of age, she had regular periods every 28 days, with a flow of three to four days duration without dysmenorrhea. She denied ever having had any venereal diseases. At nine years of age she had acute appendicitis with rupture of the appendix and generalized peritonitis. The appendix was removed surgically and the abdomen drained. The postoperative course was complicated by the development of an incisional hernia at the point of her McBurney incision.

On this admission salpingograms were taken using lipiodol® media, and it was shown that the uterine cavity was rather large but no filling defects were seen. The left tube was considerably dilated and tortuous, and no opaque media was seen to pass into the abdomen. The right tube appeared normal in its proximal two thirds. Its lateral third was quite tortuous and dilated, but again, no media passed into the abdomen. Films taken after 24 hours showed the left tube to be essentially unchanged. On the right, the dye changed position into a pocketed area at its distal end. Neither tube was patent. It was noticed that the cervix was stenosed at the internal os. This was overcome by the spiral coned cannula used in taking the salpingograms and also by the use of a stem pessary left in the cervix for six weeks.

The patient was readmitted on July 10, 1949. There were no changes or additions to the history or physical examination at this time. The last menstrual period had been on July 2, 1949. The patient was taken to surgery the following day.

A dilatation and curettage of the uterus was followed by pelvic laparotomy.

The uterus was found to be retroflexed and firmly adherent to the posterior cul-de-sac by dense adhesions. There were numerous adhesions to the parietal peritoneum, particularly at the site of the appendectomy. The left tube was adherent to the sigmoid and to the surrounding tissues. The right tube was firmly adherent to the surrounding tissues. The ovaries appeared to be normal but also involved by adhesions. After the tubes were freed of their adhesions it was noticed that the fimbriated ends were completely occluded; the tubes were dilated to the amount of 3 cms. in diameter throughout most of their course and dumbbell shaped. The appearance was typical of hydrosalpinx.

The tubes were opened by sharp dissection and found to contain the precipitated lipiodol® which had been injected for the x-ray studies three months before. The material was washed out using normal saline solution, and the diseased portions of each tube excised. A new ostium was then formed by cutting each tube longitudinally and everting the mucosa of the fallopian canal and suturing it to the serosa using intestinal 000 chromic suture. Following this procedure, approximately 4 cm. of tube remained on each side.

After it had been determined that the lumen on each side was open, several strands of #2 chromic catgut were inserted into the lumen extending to the cavity of the uterus. Each ovarian ligament was plicated and shortened using linen sutures. The tube on each side was fixed to the corresponding ovary, thus placing the newly formed ostium in close proximity to the ovary. The uterus was suspended by bringing a loop of the left round ligament one and one-half inches from the uterus through the internal inguinal ring and suturing the loop to the fascia of the rectus abdominus muscle with linen.

Because of dense adhesions, it was impossible to carry out this procedure on the right side, so the right ligament was merely plicated on itself. The uterosacral ligaments were also plicated and shortened. The abdomen was then closed by layers. The postoperative course was uneventful and the patient was discharged 10 days postoperatively.

The microscopic diagnosis on the portions of tubes removed was that typical of hydrosalpinx and chronic salpingitis.

The patient was next admitted on November 11, 1950, with a term pregnancy and in active labor. Her last menstrual period had been on January 29, 1950, six months following her operation. X-ray pelvimetry was found to be normal, and she reported an uncomplicated prenatal course. There were no complications of labor, and she delivered a normal 7½ pound male infant on the day of admission. The postpartum course was uneventful also.

In passing we might also mention that two years postpartum the patient was readmitted to the hospital for repair of the McBurney incisional hernia. During this procedure an inspection was made of the tubal plastic and it was noticed that both sides insufflated properly with saline. There were few adhesions present. The patient became pregnant again 14 months later and has had a normal antepartum course and will expect to deliver in April of 1955.

Case 2. Mrs. —, 24 years old. This patient first had the usual routine office diagnostic study for infertility. Careful pelvic examination revealed a very small uterus fixed in position and

bilateral adnexal masses; the cervix was stenosed. The patient complained of having been married three years with no success in becoming pregnant. She stated that her periods were irregular and very painful. She also stated that sexual intercourse was painful and that she had considerable vaginal discharge. She received a long course of treatment during which her vaginal discharge was overcome. Hormonal therapy regulated her periods so that she began to menstruate regularly. Ovulation temperatures recorded ovulation on approximately the sixteenth day before her next period.

The patient was admitted to the hospital for further study. Salpingograms showed bilateral occlusion of the fallopian tubes. A stem pessary was inserted and left in the uterus for six weeks. The patient was readmitted to the hospital six months later for laparotomy. The uterus was found to be rather small and very firmly adherent in the retroflexed position in the cul-de-sac. Both adnexa were firmly bound down by adhesions to the surrounding tissues. The fimbriated ends of the tubes were markedly dilated and completely closed by adhesions. This patient was treated similarly to Case 1, i. e., bilateral formation of a new ostium; ovarian and uterine suspension plus appendectomy, and saline insufflation of both tubes.

The patient made an uneventful recovery and was discharged on the tenth day. She returned to the office in about 14 months reporting an amenorrhea of two months' duration and morning nausea and vomiting. Vaginal examination revealed that she was approximately two months pregnant. The diagnosis of pregnancy was confirmed by the Friedman test.

The patient progressed well until the twenty-sixth week of her pregnancy at which time she met with an accident which caused her to go into labor. A diagnosis of premature separation of the placenta was made on the basis of physical findings which were very typical. Because the pregnancy was of such short duration the patient was allowed to deliver from below. She delivered a one pound twelve ounce baby boy which lived about four hours.

Case 3. Mrs. —, 29 years old. This patient was referred by a general surgeon. She stated that she had been married four years. There had been several infertility studies and salpingograms by other physicians. In each case she was told that she could not become pregnant because of severe pelvic inflammatory disease which had caused destruction of her fallopian tubes.

Pelvic examination showed the uterus fixed in retroflexion with bilateral adnexal masses. The husband had had children by a previous marriage. Sperm studies made on him by a urologist were found to be completely normal. Salpingograms made at our hospital showed bilateral occlusion of the tubes with marked distortion of the position of the uterus due to adhesions. At laparotomy it was noticed that she had a typical "frozen pelvis" due to pelvic inflammatory disease.

This patient was treated by the same technique as the previous two cases. Because of the extensive manipulation required to complete the operation it was thought best to treat this patient postoperatively with antibiotic therapy. The patient made an uneventful recovery and was discharged on the tenth day. She too became pregnant in about seven months and was delivered at term by cesarean section due to cephalopelvic disproportion. The male infant

weighed eight pounds twelve ounces, and the mother's pelvis was definitely funnelled.

Case 4. This patient, 25 years old, reported to the office with a history of being married five years, and never having been pregnant. She had several infertility diagnostic studies previously including about four salpingograms. She had been told that the salpingograms revealed bilateral tubal occlusion. Following the usual routine office study for infertility, she was admitted to the hospital for salpingograms. This patient had marked cervical stenosis and also a uterus firmly fixed in the cul-de-sac. Salpingograms revealed bilateral tubal occlusion. A stem pessary was inserted into the uterus and left in place for six weeks. The patient was readmitted five months later for laparotomy. She received the same type of surgical procedure as previously mentioned. The patient became pregnant in about eight months and is now about five months pregnant and has felt life for the past two weeks.

CONCLUSION

In conclusion the following points should be noted from the results obtained in these cases: it would seem advisable to do careful salpingograms on all suspected cases of tubal occlusion. Where the defect is due to some exogenous cause, and where it can be demonstrated that an adequate portion of the lumen remains patent, an attempt should be made to correct the continuity of the lumen by a plastic repair. In our opinion, a proper uterine suspension is of great help in preventing reformation of the intestinal adhesions, or at least in keeping them to a minimum and away from the operative areas. Also, shortening of the ovarian ligaments when the ovaries hang too low in the cul-de-sac, seems to allow closer approximation of the tubes to the ovaries. Direct abdominal saline insufflation of the tubes is a very accurate and satisfactory method of determining tubal patency. A soft, pliable, blunt needle of about 16 gauge is used on a 10 cc. syringe.

ADDENDUM

Since this report was submitted to *The Ohio State Medical Journal*, the patient (Case 1) normally delivered her second baby, a living female infant on April 20, 1955.

In Case 2, the patient became pregnant again and had an uneventful delivery of a living normal 7 pound 4 ounce female infant on July 12, 1955.

The patient (Case 3) also became pregnant and was delivered by cesarean section on September 25, 1955. She had a living and normal 8 pound 2 ounce male infant.

In Case 4, patient delivered a normal, full-term female infant weighing 8 pounds 10 ounces. This patient was delivered by cesarean section after a 12 hour trial of labor showed no progress and x-ray pelvimetry proved cephalopelvic disproportion. She too made an uneventful recovery.

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Allergy from Therapeutic and Diagnostic Procedures

Allergic reactions to the increasing array of therapeutic and diagnostic products is the concern of every type of practitioner. Immediate type of reactions, consisting of one or several symptoms of urticaria, abdominal pain, rhinitis, asthma, shock, or unconsciousness may result from a variety of drugs. Among these are aspirin, phenacetin, aminopyrine, phenolphthalein, contrast x-ray media, sulfonamides, hormones, vitamins, liver extract, insulin, vaccines, serum, and antibiotics. The physician must know many facts. For example, he should not be misled by the laboratory report that aspirin gave a negative result on skin tests. Aspirin, like most simple drugs, does not give a positive skin reaction, although the degree of sensitivity to it may be such that the resulting asthma is unusually severe and may even terminate fatally. Skin tests with contrast media also are of no value.

But among this group of atopically reacting drugs some give a positive skin reaction. This is particularly true of serum and penicillin. The physician should know that the patient who shows immediate urticaria or shock after a dose of penicillin would have given a positive scratch or intradermal test before the therapeutic dose was administered. Fatal reactions to penicillin are not rare and usually can be prevented by noting a number of points: previous administration of penicillin, previous reactions from the drug, the presence of other allergy, and a positive skin test. The doctor should know further that the type of penicillin used makes virtually no difference, that small amounts of penicillin are present in many samples of milk on the market (from the treatment of mastitis of cows), and that the polio vaccine contains small amounts of penicillin and streptomycin. Although most of the antibiotic activity of penicillin in the virus vaccine is destroyed by the time it reaches the consumer, there is good reason to believe that the allergenic activity remains. But only the most sensitive individuals would react to such a small amount of penicillin.—Samuel M. Feinberg, M. D., Chicago: *Illinois M. J.*, 109:129, March, 1956.

Maintenance vs. Restoration: The maintenance of health is immeasurably more important than its restoration after disease has developed.—Emil Bogen, M. D., *Dis. of Chest*, September, 1955.

Effective Surgical Treatment for Atrophic Rhinitis

WILLIAM H. SAUNDERS, M.D.

ATROPHIC rhinitis, a moderately uncommon disease, is seen frequently enough to be worthy of attention by the general practitioner, particularly in view of its distressing symptoms and the effectiveness of a recently developed treatment.

The etiology of atrophic rhinitis has never been convincingly demonstrated. The condition often begins about puberty and is manifested throughout adult life. Women are more commonly affected than men.

SYMPTOMS

There are two major symptoms. First, the patient complains of a stuffy nose. The stuffiness results partly from great green-colored crusts and partly from shrinkage of the nasal mucosa and bones, which produces a wide open airway. Paradoxically, this flue-like airway makes the patient feel as if his nose is obstructed because he lacks the sensation of pressure contact between the air current and the nasal turbinates. The second symptom is odor. Not all patients have the characteristic foul odor known as ozena, but many do. Particularly is there odor if the patient fails to use some measure for nasal hygiene such as saline irrigations. Some patients may have a third symptom, nasal bleeding. It occurs when the patient blows or picks crusts from the nasal mucosa.

Submitted November 16, 1955.



Figure 1

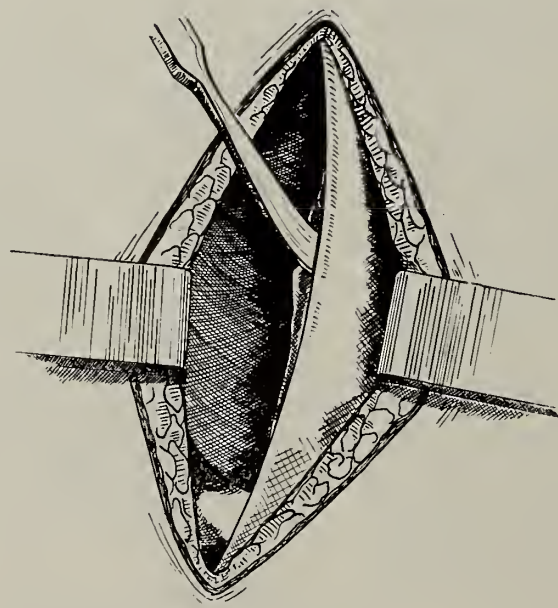


Figure 2



Figure 3

The Author

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DIFFERENTIAL DIAGNOSIS

The differential diagnosis from the standpoint of the general practitioner is chiefly between atrophic rhinitis and sinusitis. In sinusitis there is generally less crusting, and the crusts are not green-colored. There is no nasal atrophy in sinusitis, but hyperplastic mucosal changes are common.

OLDER TREATMENTS

The treatment for atrophic rhinitis for a great many years has been both medical and surgical. Medical treatments have run the gamut from simple saline irrigations to cortisone therapy. Whatever medical measures have been used have been more palliative than curative. They are aimed at local stimulation of the blood supply and nasal cleansing.

Older surgical treatments have attempted to narrow the nasal airway by displacing the maxillary bones inward, or by widening the nasal

septum. These measures were often so severe that the treatment was worse than the disease; usually they were ineffective. The use of cartilage or bone to widen the septum has been reported favorably, but in our opinion this is less physiologic than the method described here.

SIMPLE AND EFFECTIVE SURGICAL TREATMENT

The treatment used in five cases of atrophic rhinitis seen during the past year has been surgical. All were cases of long-standing, and all patients had tried various medical measures without lasting results. The method has been described elsewhere, has been used by other operators, and is simple and effective.

A piece of cancellous bone taken from the patient's iliac crest is cut into several small splinters as thick as a match and about half as long. These bone chips are inserted through small skin incisions in each nasolabial fold (Fig. 1) and packed into a pocket made by elevating the periosteum from the lateral wall of the nose. The sharp-edged pyriform crest of the maxillary bone provides an excellent landmark for beginning the periosteal elevation. (Fig. 2) As the periosteum is elevated, the shrunken inferior turbinate is easily displaced toward the septum. Packing the subperiosteal pocket full of bone chips keeps the turbinate displaced permanently and thereby narrows the nasal chambers. (Fig. 3) The inferior turbinate is displaced as far toward the septum as possible, so that the turbinate is sometimes in actual contact with the septum. There is then some postoperative retraction of the turbinate; a normal airway results.

It is preferable to use bone chips if periosteum is to nourish the graft; cartilage would be used if perichondrium were to be the nourishing membrane. Whereas foreign material such as ivory and acrylic are not well tolerated, all of these patients have tolerated the autogenous bone grafts perfectly. In each patient, the nasal crusts and odor have completely disappeared. The procedure is readily performed under local anesthesia. Neither cutting the bone graft nor placing the bone chips is more difficult than a submucous resection. The skin incisions heal without a visible scar. Patients leave the hospital in about four days.

Dermatitis of the Hands

Bacterids are apt to be pustular, and that they do occur secondary to infections of teeth, tonsils, prostate, and other organs is borne out by the work of numerous investigators. It is, indeed, fortunate when a dermatitis of the hands disappears or improves after subsidence of the infection or after administration of antibiotic drugs. Foci of infection probably play more of a contributing, or aggravating, than a causative role.—James W. Burks, Jr., M. D.; *J. Oklahoma M. A.*, 48:208, 1955.

KEEPING UP WITH MEDICINE

- IN NEW HAMPSHIRE too heavily fertilized timothy hay produced goitre in 3-month old calves.

* * *

- VIRAL HEPATITIS is one of the most common and important infectious diseases in the world today. Nearly 50,000 cases were reported in the United States in 1954.

* * *

- ALMOST ANYTHING within the living world can be considered a part or a whole, depending upon one's point of view. For instance, the liver is made up of a combination of cells. Each cell can be considered as a whole entity in itself, or a part of the more complex organ; and the liver as a whole organ or as a part of the whole animal. Maybe, therefore, it would be better if we spoke of living systems.

* * *

- THE WORK of fecal diagnosis should be conferred to a restricted area in one room. All workers who participate must be keenly aware that dangerous pathogenic bacteria and viruses may occur in fecal specimens and certain of these can be transmitted not only to the worker but also to visitors and even to the janitor and plumber.

* * *

- PASSIVE transfer tests in infants have now given way to cleaning the skin with steroids and then testing the youngster's own skin directly.

* * *

- GOAT'S MILK is only occasionally more helpful than evaporated cow's milk in treating milk allergy.

* * *

- THERE is a definite increase in the number of severe and fatal anaphylactoid reactions after the administration of penicillin. These reactions are more frequent in allergic persons; in patients who have taken the drug before, especially if there had been a mild reaction with the last dose; in patients who get large doses; and in patients who are under treatment with the drug for a long time.

* * *

- CLINICALLY, it has been observed that several patients have developed tuberculosis while on corticosteroid therapy, although there has been no evidence of the infection before the steroid therapy.

* * *

- SEBORRHEIC DERMATITIS is the most common dermatitis in infancy.

* * *

- REMARKABLE EFFECTS on the symptomatology of amebiasis have been produced by certain of the antibiotics but these effects seem more likely to have been due to action against bacteria and so follow-up treatment with amebicidal drugs is usually necessary.—J. F.

Control of Hemorrhoids by the Patient

J. G. ROSENBAUM, M. D.

THE number of patients with chronic hemorrhoid disease who have been successfully treated on a medical basis, has in the writer's practice, been increased considerably with the introduction of a series of instructions to those sufferers. So effective has been the treatment, that except for a very few patients who have received injections of sclerosing solution, less than one patient per year has been referred for surgery.

Basis of treatment is the explanation to the patient of the principle of hydrostatic pressure and how the hemorrhoidal veins become engorged by that pressure when the anal sphincters are maintained in a relaxed state for a prolonged period. The habit of reading or smoking while sitting at stool is condemned and the method of damage by that procedure, carefully explained.

Another factor which appears to help in control, is the avoidance of straining at stool. This is accomplished in most patients by the use of some of the common hemorrhoidal suppositories with a cocoa butter base which keeps the anal canal lubricated, plus instructions to the patients to wait for a very definite urge to defecate before sitting at stool. The patient is reminded that when the urge to defecate is strong, no straining is required to evacuate. Instructions are given as follows:

INSTRUCTIONS FOR HEMORRHOID CONTROL

Use a suppository once daily for one week, then every other day for one week. Return for consultation at the end of two weeks, but sooner if any difficulties should be encountered.

Make no effort to be regular. Wait for a strong urge to defecate, then hasten to sit at stool.

Do not strain at stool. Relax the muscles of the anus. Straining may be avoided by breathing deeply through the mouth. If you have waited for a strong urge to defecate, you will pass the stool without effort.

As soon as the first stool has passed, attempt to close the anus by "tightening" the muscles. Wipe immediately using a facial type tissue. Rise and leave the bathroom at once.

Ordinarily, when moving the bowels, one will remain seated with the anal muscles relaxed until a second small stool passes or until the pressure in the rectum is abated. You must never do this since it is at this time that most of the damage occurs. Should you, after about 15 minutes, still feel the need to defecate, you may return to stool and repeat the procedure. This is usually unnecessary as the continued desire to defecate disappears within a minute or two after standing. The habit of reading or smoking while sitting at stool cannot be too highly condemned.

It is wise to increase the quantity of high

The Author

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residue foods, salt and water in the diet to assure avoidance of constipation in those so inclined.

These instructions, although not universally effective, have controlled most cases of chronic hemorrhoids seen by the author in his practice. Most persons who have had difficulty in the past will avoid a recurrence of symptoms by following these instructions. Patients are urged to return for consultation if any difficulties arise.

The author feels that there are many problems which are not controlled by these procedures, but that most patients do respond and are entitled to a trial of this regime before surgery is offered.

Emphasis on Recognition of True Renal Glycosuria

True renal glycosuria is a benign condition characterized by the presence of glucose in the urine at all times, even in the fasting state, and at all levels of blood sugar. It is a rare condition. It is important to differentiate true renal glycosuria from diabetes mellitus for the treatment is entirely different. In true renal glycosuria, insulin is contraindicated and adequate carbohydrate intake must be furnished.

It is inherited as a Mendelian dominant, is benign and persists throughout life once it develops. The ratio of male to female patients with true renal glycosuria is three to one. It may occur at any period from infancy to old age. The pathology is not known. No autopsy in such case has been reported.

The criteria for the diagnosis of true renal glycosuria are as follows: (a) A fasting blood sugar within normal limits or lower than normal; (b) glucose tolerance curve is normal or flat; (c) glucose is present in every specimen, whether voided in the fasting state or after a meal; (d) carbohydrate utilization and fat metabolism are normal.

True renal glycosuria, because it is rare and frequently confused with diabetes mellitus and with other forms of non-diabetic glycosuric meliturias, is worthy of emphasis.—Daniel H. Goodman, M. D., Phoenix: *Arizona Medicine*, 13:88, March, 1956.

Submitted May 24, 1955.

Planing Treatment of the Skin (Dermabrasion) for Scars*

RAYMOND S. ROSEDALE, M. D.

VICTIMS of acne vulgaris and other disfigurements, whose scarred and pitted faces have made them the target of sneers and jokes through the centuries, now can be offered promises of normal lives through a relatively new and different treatment technique.

The method is skin planing—use of fine stainless steel brushes to create a common level of skin and eliminate depressed and raised areas made unsightly by changing shadows from the play of light on them. The treatment well may be called spectacular, for the transition from rough to smooth skin is unbelievable unless personally viewed. Popularity of skin planing is increasing and the author predicts it will become commonplace in coming years. It has many advantages over previous methods, such as use of sandpaper, and none of the disadvantages.

While it is particularly applicable to treatment of the facial area, it has been used with success on wrists, hands and forearms, and well could be applied to any other area of the body. In three years of use by the author, marked improvement has been noted in all cases.

Skin planing as outlined here first was described by Kurtin in 1952. Previously, in the early 1900's, Kromayer¹ founded modern cosmetic surgery in the dermatological sense. He utilized cylindrical knives powered by ordinary dental motors which were applied vertically to the skin, and also employed steel burrs and rasps.

Iverson (1947)² first used carpenters' sandpaper wrapped around a three-inch roll of gauze bandage to remove traumatic tattoos. General anesthesia was required. The following year, McEvitt³ was first to apply sandpaper for correction of acne pits, with the entire face being abraded by hand.

Kurtin⁴ presented his method of refrigeration-abrasion skin planing at a meeting of the Dermatological Section, Mt. Sinai Hospital, New York City. By freezing large areas of skin with ethyl chloride, he eliminated the need for general anesthesia and made his treatment an office, rather than a hospital, procedure. He devised the motor-powered wire brush for the abrading process which is used today.

Use of the brush with ethyl chloride is considered superior to sandpaper because the skin is stable and frozen and does not slip. Another disadvantage of sandpaper, other than requiring anesthesia, is the danger of particles of sand be-

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coming imbedded in the skin and acting as foreign bodies. Also, hard-to-reach, small areas, such as those around the eyes, can be treated as successfully as any others by the brush process.

Planing is painless, inexpensive and relatively simple to perform. It requires but a small amount of equipment. There are no postoperative complications and no periods of bedfastness. The period of social disability averages only five days. No anesthetic is needed for adults, although general anesthesia is required for children. Both active and quiet lesions can be treated, and the treatment can be repeated until the desired degree of improvement is obtained.

In addition to acne, these conditions respond well to the planing procedure: Smallpox and chicken pox pits; scars, whether due to accident or elective surgical procedures; pigmentations like those which occur in pregnancy; pigmented nevi; lesions such as flame nevi; those resulting from trauma and elective tattoos, if not through the full thickness of the skin; multiple sebaceous adenomata (for which no other satisfactory treatment has been developed), and superficial epitheliomata. It can be used to treat keratoses, both senile and seborrheic, and to improve wrinkles.

The treatment is not applicable to keloids and but limited success has been noted with burn scars, because of the destruction of hair follicles.

Prior to use of the technique, the patient, who naturally will be apprehensive, should be given a careful and detailed account of the procedure, the postoperative course and what may be expected in the way of improvement. His fears of pain or discomfort should be allayed. He should be informed not to expect miracles and he should be advised several treatments may be required after the original one.

Whenever possible, the author has a qualified dermatologist present for preoperative consultation.

PREPARATION OF PATIENT

When the operator is ready to proceed with planing, the patient is placed on a table, castor oil

*Extension of remarks presented in Miami, Florida, at the January 1955 meeting of the American Otorhinologic Society for Plastic Surgery.

Submitted October 19, 1955.

is applied to his eyes and his face is cleansed with alcohol. The skin is sprayed with ethyl chloride from a distance of 18 inches, to freeze the skin.

Eller⁵ and others have described use of a current of air from a blower, directed on the surface simultaneously to accelerate evaporation of ethyl chloride, but we have found a blower unnecessary. We also have found it unnecessary to cover the area to be treated with an ice pack before applying the ethyl chloride. Patients have not complained of any burning sensation such as has been recorded by others.

EQUIPMENT

The Kurtin Plastic Planer is used. Its operating accessories consist of a set of four rotary-type planing brushes, $\frac{3}{4}$ inch in diameter, packed with surgical type stainless steel strands held compressed together by two metal discs. The solid mass of exposed wire ends forms the cutting face of the planing brush, and several different widths are available.

The brushes are attached through a flexible handpiece, and rotate to 12,000 times a minute by a 1/12 hp. motor. Speed is controlled by a foot pedal.

Other equipment necessary includes a face shield to protect the operator from epithelial debris, ethyl chloride with coarse jet valve, plastic gown, a good light and examination table of comfortable height.

OPERATIVE TECHNIC

The planing procedure is applied immediately upon use of the ethyl chloride. An area two inches square is frozen at one time. Caution must be used not to freeze the skin too deeply. This is a matter of judgment, and the correct depth can be learned only through practice. Depth of planing also is a matter of judgment. It is better to underplane and come back than to go too deep.

In planing, the revolving brush is placed horizontal to the skin and is moved at right angles to the plane of rotation. Planing in the line of rotation can produce grooving. The skin is kept taut with one hand and the brush is applied with the other.

The entire face can be done at one sitting, if the patient is cooperative, not unduly apprehensive and the room is well-ventilated. Planed areas can be blended into the temples and along the angle of the jaw and chin by gradually feathering strokes toward uninvolved areas. Sharp delineations thereby are avoided.

In planing around the eyes, firm pressure must be applied at the eyelids. When an area near the hairline is to be treated, adhesive tape should be used to hold the hair safely away from the brush. A finger inside the patient's mouth on the movable pad aids treatment around the lip by giving a more solid working surface.

Free bleeding ensues. When planing is com-

pleted, the treated area is cleaned with hydrogen peroxide, then is covered with terramycin® ointment and xeroform® gauze. We have found no need for use of oral antibiotics.

POSTOPERATION

The dressing is removed in the office in three days, and aeroplast® is sprayed on and allowed to dry. We permit our patients to apply powder makeup once it is dry. The aeroplast® is peeled off on the seventh postoperative day.

The new skin is pink. Erythema disappears without complication in four to six weeks. Sequelae mentioned by Edelstein⁶ as occurring occasionally—persistent erythema, hyperpigmentation, milia, pyoderma and eczematous reactions—have not been noted by the author.

Repeated planings to a maximum of five have not been found necessary in most cases, and are done at four to six week intervals. The number of treatments necessary depends on evaluation of the situation. Each repetition can be expected to give improved results, since more pits are eliminated. The process is ended when the operator feels results to be obtained from further planing no longer balance discomfort of the procedure.

After use, brushes are motor driven through cold water, alcohol and ether, and are air dried.

Improvement in appearance is marked in all cases, but varies depending on nature of the scars and character of the skin. Experienced operators find little difficulty in arriving pre-operatively at a fairly accurate estimate of the degree of improvement to be expected.

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Musculoskeletal Pain

There is no problem facing the physician which presents more frustrations, more challenge, than does the attempt to relieve pain in the musculoskeletal system. The more of these cases that I see, the more I am convinced that there is a segmental distribution of pain, as for example, in the so-called shoulder arm syndrome; although the identification of local pathological conditions causing the symptoms usually is a very difficult one. One may be confronted with a problem in which the entire neck, the arm, including the fingers, all are involved. Similar situations may involve the lumbar region, the hip and the lower extremities.—Joseph H. Giesen, M. D., Waterville, Me.: *J. Maine M. A.*, 47:39, February, 1956.

Hyaline Membrane Disease of the Newborn

A Pediatric Review

LOUISE W. RAUH, M.D.

HYALINE membrane disease is thought to be responsible for more deaths of live born infants than any other single cause. Potter¹ states that in the Chicago Lying-In Hospital hyaline membrane was present as the only pathologic change in 40 per cent of all infants weighing 1,000 to 2,500 grams dying in the years 1939 to 1949. It has been estimated that 20,000 babies die of this process yearly in the United States, or at least that the membrane is the only significant pathologic finding at autopsy in these infants. These statistics speak for themselves. If neonatal mortality and morbidity rates are to be reduced, we must learn more about the cause, the pathogenesis, and the prevention of this disease.

In 1903 Hochheim² first reported the existence of a peculiar membrane found in the lungs of two newborn infants at autopsy. However, it is only in comparatively recent years that the importance of this membrane as a cause of respiratory distress and death in the neonatal period has been appreciated.

CLINICAL AND PATHOLOGICAL PICTURE

The clinical picture of the hyaline membrane is a fairly characteristic one. The syndrome or disease occurs most frequently in premature infants weighing more than one kilogram, in both premature and full term infants following cesarean section, and in infants born of diabetic mothers. Winter and Gellis³ reviewed the autopsy findings and the microscopic sections of the lungs of 40 babies born of diabetic mothers from 1935 to 1951. In 21 of these infants hyaline membrane was the only finding as a cause of death. Of the 22 delivered by cesarean section, 68 per cent had hyaline membrane formation. Fifty-three per cent of the infants delivered from below also showed this abnormality.

The infant who develops this syndrome breathes spontaneously at birth and normally for the first hour or few hours thereafter. Symptoms invariably appear within 12 hours after delivery. These may be a gradual or a precipitate onset of respiratory distress accompanied by cyanosis and marked retractions of the lower thoracic cage and sternum. The respirations become more and more labored, and on physical examination breath sounds become less audible. Death due to exhaustion and inability to obtain sufficient oxygen may occur anywhere from 8 to 48 hours. Roentgen examination of the lungs is unsatisfactory. Early in the disease no pulmonary abnormality

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is visible. Later the lungs may appear diffusely hazy.

If the infant survives for 48 hours, an inflammatory process may be superimposed on the membrane and infants dying after 48 hours have pathologic evidence of pneumonia. In those infants who recover, symptoms usually begin to abate after 48 to 72 hours and gradual improvement follows.

Hyaline membranes have never been found in stillborn infants. It is apparently necessary for an infant to have breathed in order to develop this condition.

At autopsy the lungs are the size of well expanded lungs, but have the consistency of liver and are dark red-purple in color. Histologic examination reveals widespread atelectasis; the walls of many alveolar ducts and alveoli are collapsed. There is intense capillary engorgement. The inner surfaces of the alveolar ducts which have remained open are covered by an irregular layer of homogeneous acidophilus material. The presence of fat, and occasionally cornified epithelial cells and lanugo hairs in the membrane gave rise to the name vernix membrane by which term this membrane was formerly designated.

The membrane forms a mechanical barrier to normal respiratory exchange by blocking off some portions of the pulmonary tissue and by coating the remainder in such a way that the capillaries are deprived of contact with the oxygen-containing atmosphere. Potter¹ has found an increase in subarachnoid fluid in infants dying after cesarean section with hyaline membrane.

PATHOGENESIS

In general, three basic concepts have been developed for the origin of the pulmonary hyaline-like membrane. The first concept attributes the membrane to the inhalation of amniotic fluid with continuous concentration of the amniotic fluid protein in the respiratory bronchioles, alveolar ducts, and alveoli. After birth when extra-uterine breathing begins, the membrane formed by the concentration of amniotic protein material

Submitted February 10, 1956.

produces obstruction to aeration and leads to atelectasis. The presence of fat in the membrane and cornified epithelial cells lends support to this theory.

The second concept hinges on the derivation of the protein material from the blood, rather than the amniotic fluid. This concept is supported by numerous examples of disease in older children and adults in which vascular damage, particularly of capillaries, is responsible for the loss of protein and the formation of hyaline membranes, e. g., rheumatic pneumonitis, radiation pneumonitis, sulfonamide pneumonitis, war gas poisoning, etc. Recent investigative work to be discussed below supports this concept.

The third concept includes the first two and proposes that the membrane is formed by the interaction of aspirated amniotic fluid with elements contributed by the infant.

REPRODUCTION OF THE MEMBRANE IN ANIMALS

Stevenson and Laufe⁴ have been the first to produce experimentally in animals the triad of hyaline membrane lining and distending the alveoli and alveolar ducts, massive atelectasis, and intense capillary engorgement. They injected a mixture of human amniotic fluid and human plasma into the tracheas of adult guinea pigs. Many of these animals developed the severe pulmonary distress seen in newborn infants suffering from the pulmonary hyaline membrane syndrome. At autopsy the lungs were as described in the foregoing.

These authors believe that the injected plasma caused an intrapulmonary exudation of fluid and pulmonary vascular engorgement. The injected amniotic fluid created atelectasis and its thromboplastin-like activity aided in clotting the exudate to form a membrane. They suggest the following sequence of events in the formation of the membrane:

(1) The newborn infant aspirates amniotic fluid.

(2) The lungs exude a high protein fluid as a result of vagal injury, irritation from amniotic fluid, administered oxygen, anoxia, or other noxious influences.

(3) The amniotic fluid speeds clotting of the exudate which "rings" out on the walls of the alveoli and alveolar ducts. As fluid is absorbed, the exudate forms a hard membrane.

(4) Plugs of clotted exudate in the terminal bronchioles create extensive atelectasis and the hyaline membrane which seals the alveoli and alveolar ducts causes local atelectasis and dilated air spaces.

(5) Anoxia increases with this process until asphyxia occurs.

(6) If changes are minimal and there is time for a leukocytic response, the leukocytes attack

and resolve the membrane, allowing return of aeration and recovery.

CHEMICAL COMPOSITION OF THE MEMBRANE

The exact chemical composition of the membrane has never been fully determined. Until recently all that has been known of its composition is that the membrane was formed of protein to which a carbohydrate fraction is attached and that it also contained some fat. Gitlin and Craig⁵ studied the lungs of five newborn infants dying with this syndrome by fluorescent antibody and dye staining procedures. Human amniotic fluid was examined by the same methods. They found that the hyaline membrane was composed largely of fibrin. Small amounts of fibrin were found in the amniotic fluid, but the quantity was extremely small in comparison to that found in the membrane. These investigators believe that the fibrin in the hyaline membrane is converted from fibrinogen by the thromboplastin of amniotic fluid. They postulate the following:

(1) Insoluble fibrin cannot be transferred across capillary or cellular membrane.

(2) The fibrin must be formed *in situ*.

(3) Fibrinogen can migrate across capillaries and even normal capillaries are permeable to fibrinogen.

(4) The presence of the fibrin membrane indicates the existence of an effusion from the pulmonary circulation at one stage in the development of the membrane.

Thus, the following steps in the formation of hyaline membranes may occur: (1) Effusion from the pulmonary circulation resulting in the presence of fibrinogen and other plasma proteins in alveoli and alveolar ducts. (2) Conversion of fibrinogen to fibrin, which may be enhanced but not necessarily dependent upon the presence of thromboplastic material in aspirated amniotic fluid. (3) Coagulation of the fibrin network to form a membrane.

PATHOGENESIS OF PULMONARY EFFUSION

The pathogenesis of the pulmonary effusion is still unanswered, but Miller and co-workers⁶ and Lendrum⁷ have some interesting ideas on this subject. Miller and co-workers were able to produce pulmonary hyaline membranes similar in appearance to those seen in newborn infants in 13 of 20 rabbits on which vagotomy was performed bilaterally in the mid-cervical region. Pulmonary edema and hemorrhage into the alveoli was marked. The cause of the edema was thought to be due to obstructive asphyxia, aspiration of stomach and oral contents and interruption of neurogenic impulses from reflex centers in the brain. These investigators believe that whatever factors were responsible for the pulmonary edema were also concerned with the production of the membrane.

The obstructive asphyxia probably results from

approximation of the vocal cords following the vagotomy and the pulmonary edema is probably largely dependent on this factor. The trachea and bronchi readily fill up with the material from the oral cavity. The elimination of both of these factors considerably reduced the pulmonary edema but did not eliminate it and for this reason the authors believe there is another factor, possibly a neurogenic one, which also plays a role in the production of the edema. It is not unreasonable to suppose that obstructive breathing can occur in premature infants as a result of collapse of the laryngeal structure, trachea, or bronchi on inspiration because of the hyperflexibility of these organs. Breathing of this type is comparable to that occurring in vagotomized rabbits. Certain premature infants find it difficult to keep the trachea and bronchi free of oral contents.

The matter of the neurogenic component accounting for changes in the lungs of newborn infants is possible and needs further consideration, particularly since there is considerable evidence that pulmonary edema can be produced experimentally by increased intracranial pressure.

LEFT HEART FAILURE—CAUSE OF PULMONARY EDEMA

Lendrum⁷ too, believes pulmonary edema is the basic underlying cause of this syndrome. He attributes the edema to left heart failure. He believes the cardiovascular system in premature infants is not ready to make the adjustment required for extra-uterine life; that failure to make these adjustments imposes an excessive load on the pulmonary vascular bed. At birth the volume of blood returning to the right auricle falls, causing a fall in pressure and closure of the foramen ovale. The pressure in the right ventricle falls too, following inflation of the lungs and decrease in pulmonary resistance.

The increase in pulmonary blood flow causes an increase in blood to the left atrium and the pressure rises in this chamber, insuring a physiologic closure of the foramen ovale. The pressure in the left ventricle also increases when the widely open placental circulation is cut off and all the blood must be pumped through the more resistant systemic circulation. This imposes a sudden increased load on the left ventricle, the muscular wall of which is not prepared for this load. In addition, if the ductus fails to close when the pressure in the aorta rises above that of the pulmonary artery, congestion of the pulmonary vessels will follow.

The limited capacity of the pulmonary capillary bed in the premature infant will cause a rise in pulmonary blood pressure as soon as there is a sizeable increase in pulmonary blood volume. This in turn will be followed by filtration of blood serum from the capillaries into the alveolar air spaces. This layer of edema fluid and blood serum imposes a growing barrier to oxygen exchange between the air and the capillaries. The

left ventricle will receive blood that is less and less oxygenated and progressive failure of the left heart adds further back pressure to the pulmonary vascular bed.

As the left heart fails, pressure rises in the right heart and this in turn opens the foramen ovale with a renewed right to left shunt. If the ductus is still patent it too may reopen. The circulation through the heart will return to the fetal pattern, reducing the pressure in the pulmonary vessels. Thus the fluid and electrolyte content of the edema fluid will be absorbed. The protein of the edema fluid, because it is less readily absorbed, will remain and become concentrated. Contraction of the elastic alveolar walls forces the protein and any fluid remaining toward the alveolar ducts and respiratory bronchioles.

In addition to left heart failure, Lendrum believes the usual method of handling premature infants increases the thoracic venous load and increases pulmonary congestion. Most prematures are placed on their backs and are moved and handled as little as possible. Frequently the foot of the bed is elevated to an angle of 30 degrees. This position causes an engorgement of the systemic veins in the thorax which usurps part of the limited space within the chest. This position likewise forces a maximal load of venous blood upon the right heart and thereby increases the liability to congestion of the pulmonary vessels. Immobility predisposes to venous stasis which itself can cause edema in the dependent portion of the lungs.

Lendrum suggests positioning and handling the premature infant with the object of avoiding overload in the thoracic veins and pulmonary circulation and even goes so far as to believe that in many cases it is possible that congestive pulmonary failure could be prevented. The position of the newborn infant during the first 48 hours should be such that any excess venous blood would accumulate below the diaphragm.

ROLE OF PULMONARY EPITHELIAL SECRETION IN MEMBRANE FORMATION

An entirely different approach to the nature and etiology of the pulmonary hyaline membrane is that of Lynch and Mellor.⁸ Using special staining methods they studied the lungs of premature infants dying of this disease. They found that the epithelium of the respiratory bronchioles and alveolar ducts contained a selective concentration of granules with similar staining reactions to those of the membrane. These findings led them to believe that the membrane is a secretion of this epithelium. They believe the membrane represents a concentration of excessive secretion of the epithelial cells of the respiratory bronchioles and alveolar ducts. This secretion is probably a metallic (copper or iron) component of a system which plays an active role in

the transfer of oxygen across the lung hemoglobin barrier.

These investigators found that non-respired lungs are relatively poor in this secretion. It is possible that oxygen is required for the activation and/or secretion of this substance or substances. If oxygen is necessary to activate this secretion it would answer the question, "Why does hyaline membrane not develop within one hour after birth?" The possibility is also proposed that the amount of the secretion may be in proportion to the amount of oxygen to which the lungs are exposed. The deleterious effect of high oxygen tension on the production of retrolental fibroplasia has been proved. The same deleterious effect may be effective in the production of hyaline membrane. It is true that in one newborn nursery since the use of oxygen has been curtailed not only have there been no cases of retrolental fibroplasia, but there has also been a marked reduction in the incidence of hyaline membrane disease.

PROPHYLAXIS AND TREATMENT

Prophylaxis of this disease begins in the prenatal period. Prevention of anoxia *in utero* and during delivery is of utmost importance. This includes avoidance of maternal hypotension or hypoxia, prevention of narcotization of the fetus by the misuse of general anesthetics or analgesics, good obstetric judgment in the choice of delivery by cesarean section, mitigation of degree of prematurity, performance of routine episiotomy in the delivery of premature infants who are more liable to cerebral injury from the normal birth process.

After delivery preventive procedures include aspiration of the stomach contents of all infants born by cesarean section and postural drainage of all infants except where evidence suggestive of cerebral hemorrhage is present. If one believes Lendrum is correct in his belief in thoracic venous overload, postural drainage would be contraindicated. In addition, infants born by cesarean section should be treated with oxygen and mist and all infants weighing less than 1,500 grams should be similarly treated. The oxygen concentration should be kept at 40 per cent or below.

The treatment of infants showing any signs of respiratory distress includes oxygen, mist and antibiotics. If there is any indication of heart failure, the infant should be digitalized.

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The Story Behind the Word

Some Interesting Origins of Medical Terms

Papaverine—An alkaloid obtained from opium in 1848 by Merck. The term is derived from the Latin name for the poppy plant which is "papaver." This in turn is said to come from the ancient Roman custom of mixing the poppy plant with a child's food (pap or pabulum in Latin) to relieve the colic and to induce sleep.

Pannus—Medically this term denotes a vascularization with thickening and opacity of the cornea of the eye. "Pannus" is a Latin word meaning cloth and the term came to be descriptively applied to this eye condition because it was likened to a cloth over the eye.

Vagina—The ancient Romans commonly referred to the female genitalia as the "vagina" which literally means a sheath or scabbard and in turn the male genitalia or penis was referred to by them, as the "gladius" or sword. The term "vagina" was adopted from its present anatomical meaning in the sixteenth century by the Italian anatomist Realdo Colombo and Gabrielle Fallopius.

Satyriasis—This term denoting inordinate sexual desire in the male is of mythological derivation. In the Greek mythology a Satyr was a demigod of the woods and was represented as being half man and half goat. The Satyrs were represented as being repulsive in appearance and animal-like in their habits. They pursued and were a terror to the nymphs of the woods. The term is an ancient one and Aretaeus of Capadocia in his book, *On the Causes and Symptoms of Acute Diseases*, written in the second or third century had a chapter on Satyriasis.

Snore—Snort—Snore is an echoic word imitative of the sound produced by the act. Derived from snore is the term "snort," meaning to violently and noisily blow air through the nose.

Arachnoid Membrane—This anatomical structure derives its name from its spider-web-like appearance. Arachnida is the scientific name for spiders and is derived from the Greek mythology. According to legend, Arachne was a beautiful young girl who could spin very well. She was quite boastful and boasted that she was better than the Goddess Minerva. In a contest with Minerva, Arachne defies and bests the Goddess. As a punishment Minerva touched Arachne on the head and turned her into a spider, condemned to spin forever.

—HARRY WAIN, M. D., Mansfield, Ohio.

Proceedings of the Ohio Society of Pathologists

Reported by PAUL N. JOLLY, M. D., Cincinnati, Ohio

THE fall meeting of the Ohio Society of Pathologists was held at the Department of Pathology, University of Cincinnati College of Medicine on Saturday, September 17, 1955, at 2:00 p.m. The meeting was well attended by members from all portions of the state, as well as by several visitors from neighboring states.

SCIENTIFIC PROGRAM

The first paper of the Scientific Program, "Interstitial Xanthomatosis of the Kidney," was presented by Dr. Salvador Adriano. The xanthomatoses are a loosely related group of diseases characterized by the deposition of lipid material in the tissues. Xanthoma is usually reserved for the occurrence of these lipids in a limited nodule, while the term xanthomatosis usually indicates multiple foci which are either circumscribed or diffuse.

XANTHOMATOSIS OF THE KIDNEY

Three cases of xanthomatosis of the kidney were presented. All were in colored males. Clinically, all showed hypertension and, pathologically, evidence of glomerulonephritis, which was subacute and chronic in two and membranous in one. Urinary function tests performed in only one of the three cases showed a phenolsulfonphthalein excretion of 0, a urea clearance of 3.5 per cent, a low, apparently fixed, specific gravity varying between 1.001 and 1.003, and a blood urea nitrogen of 174 mgm. per 100 ml.

The lesions are seen macroscopically as poorly defined nodules and streaks of yellow which are generally confined to the renal cortex. Microscopically they consist of aggregates of foam cells infiltrating the interstitial tissue. On gross examination, the lesions must be differentiated from a variety of conditions including calcinosis, gout, subacute glomerulonephritis, acute pyelonephritis, and uric acid infarcts in infants. Several theories regarding the pathogenesis of these lesions were presented.

MICROSPECTROSCOPY IN PATHOLOGY

The second paper, presented by Dr. Boris Gueft, was "Microspectroscopy in Pathology." A century ago Virchow theorized that at some time the usual methods of chemistry and physics would be applicable to cellular pathology. In a brief presentation Dr. Gueft showed how such methods are now being utilized by the pathologist and how the use of one tool will frequently substantiate or supplement information obtained by another.

Submitted January 27, 1956.

Chemical determinations have shown that the basophilia of cellular nuclei is due to desoxynucleic acid (DNA), while the cytoplasmic basophilia is due to ribonucleic acid (RNA). The spectral absorption curves of the various cellular components are sometimes quite characteristic and can be utilized in semiquantitative determinations of the concentrations of these materials. By such means, it has been demonstrated that all normal cells of the body contain the same amount of DNA, except for the haploid spermatozoa which contain half this amount. In the presence of neoplasms, concentrations of DNA up to 15 times normal have been reported.

By use of the spectroscope, oxyhemoglobin extracted from cells shows an absorption curve identical with that found within cells. By similar means, it has been shown that the amyloid of tuberculosis is different from that found in certain other types of secondary amyloidosis, as determined by ultraviolet absorption spectra of material in conventional histologic sections. Dr. Gueft also showed some recent work in which the relative DNA content of cells in malignant lymphomata is the same as in normal cells, a finding usually not observed in most carcinomas and sarcomas.

CYSTIC DISEASE OF RENAL PYRAMIDS

The third paper, presented by Dr. William Collins, was originally entitled "Paracalyceal Cystic Disease of the Kidney." At the onset of his presentation he said he wished to modify this name to "Cystic Disease of the Renal Pyramids." He presented a case (#568 from the Slide Library), the retrograde pyelograms of which showed multiple grapelike nodules attached to the calyces. Conservative therapy was used until the patient developed acute pyelonephritis, for which a nephrectomy was done.

In the medullary portion of the kidney were multiple cysts up to 1.2 cm. in diameter. These had a cuboidal to a low columnar lining. In most, no communication could be readily demonstrated between the cysts and the calyces. Four or five cysts with communicating ostia were identified.

This lesion is to be differentiated from medullary cysts occurring in small kidneys: these are usually associated with anemia and uremia. The pathogenesis of these lesions was briefly discussed. During the formation of the kidney, branching of the metanephric tubules produce the collecting tubules. The first generation of these tubules is vestigial and rarely goes on to glomerular formation. The second and third generations of these tubules become incorporated into the

expanding renal pelvis. The later generations become the collecting tubules of the mature kidney. Persistence of the tubules of the early generations is thought to give rise to these cysts.

THE RETICULUM CELL

The concluding paper of the Scientific Program was presented by Dr. Edward A. Gall. The paper was entitled "The Reticulum Cell, What Is It?" In an attempt to identify accurately the reticulum cell, Dr. Gall reviewed 100 authoritative descriptions of this cell, as it occurred in the neoplastic lesion of reticulum cell sarcoma. This analysis showed a complete lack of agreement between these authoritative descriptions in terms of the location of the cell in a normal body, its function, its size, its configuration, the quantity and character of the cytoplasm, the nuclear configuration, and even the character and distribution of the reticulum which it produces.

In the hands of the pathologist, the reticulum cell can serve one useful function: to identify to the clinician a malignant tumor of lymphopoietic origin which is composed of immature cells other than lymphoblasts.

* * *

ABSTRACTS OF CASES FROM SLIDE LIBRARY

Dr. Edward A. Gall, Professor of Pathology, served as moderator for the slide library.

Case 557: Presented by Dr. Edward A. Gall, Cincinnati General Hospital.

A 63 year old white man was dead on arrival at the hospital on January 1, 1955. He had rheumatic fever in 1917, and subacute glomerulonephritis in 1940. There had been recurrent bouts of congestive heart failure since 1940. In October 1954, a positive serologic test for syphilis on blood and spinal fluid was discovered and he received 21 million units of penicillin. Shortly before death he suddenly experienced epigastric pain and shortness of breath. He expired shortly thereafter.

Autopsy revealed marked cardiac hypertrophy and dilatation, luetic aortitis and pulmonary edema. The liver weighed 1,700 grams. The surface was smooth and glistening. Sections showed prominent central veins. The consistency was normal.

Low-power views showed smudged portal areas throughout the liver which were due to an infiltration with lymphocytes and macrophages. The hepatic parenchyma showed no fatty changes. Occasional hyalinized necrotic liver cells were present, as well as small foci of necrosis infiltrated by lymphocytes.

Diagnosis: *Infectious hepatitis.*

Case 558: Presented by Dr. Edward A. Gall, Cincinnati General Hospital.

A 76 year old man was admitted to the hospital on December 4, 1953, with hematemesis and melena. He was said to be an alcoholic and had been at another hospital in 1951 for malnutrition, tarry stools and probable cirrhosis. In March 1953, he was edematous and icteric. He vomited blood for the first time on the day of admission. He was not jaundiced, and the liver and spleen were not palpable. Tarry stool

was seen on rectal examination. Despite transfusions he continued to bleed and died on the second hospital day.

Autopsy showed ruptured esophageal varices with massive gastrointestinal bleeding. The liver weighed 1,040 grams. It was yellow tan and finely nodular (1 mm.), and there was increase in consistency.

Thin fibrous septa stretching from portal area to portal area subdivided the liver into multiple nodules composed of one or more lobules. The septa were infiltrated by lymphocytes and showed increased numbers of bile ducts. Central veins were present.

Diagnosis: *Post-hepatic cirrhosis with active hepatitis.*

Case 559: Presented by Dr. Salvador Adriano, Cincinnati General Hospital.

A 40 year old colored man was a known alcoholic with advanced cirrhosis and ascites. One year before death, a spleno-renal anastomosis was attempted. Due to technical difficulties, the procedure was abandoned and a splenectomy was done. A few weeks before his final hospital admission, he sustained a fracture of the left mid-femur and a compound comminuted fracture of the left tibia and fibula following an automobile accident. After several weeks in the hospital, he expired in shock with hematemesis and melena.

At autopsy ruptured esophageal varices and massive gastrointestinal hemorrhage were found. The liver weighed 2,175 grams. It was nodular and hard to cut. The nodules varied in size from 1 to 5 mm. Thick bands of connective tissue coursed between the nodules. Thick, irregular, fibrous septa subdivided the liver into nodules composed of one or more lobules. Bile ducts were present in increased numbers. A few inflammatory cells were present.

Diagnosis: *Post-necrotic cirrhosis.*

Case 560: Presented by Dr. Franklin Cox, Cincinnati General Hospital.

A 44 year old man was a chronic alcoholic for 25 years. He had ascites, which increased gradually until his final admission. On admission on February 27, 1951, he had tremendous anasarca, spider angiomas over the chest and slight jaundice. The liver was enlarged. Liver function tests were abnormal, and the total bilirubin was 10.5 mgm. Paracentesis yielded 4 to 6 liters of straw-colored fluid. His condition deteriorated and he expired four days later.

At autopsy the liver weighed 5,035 grams. The cut surfaces were tawny-yellow with lobular markings obscured by diffuse fine nodulations. Delicate bands of connective tissue were apparent between the nodules. The large liver cells were filled with clear vacuoles. There was accentuation of lobulation by the presence of thin and thick irregular scars stretching between the triads and streaming out into the lobules. This fibrous tissue showed a lymphocytic infiltration. The bile ducts were reduplicated. Central veins were not prominent.

Diagnosis: *Nutritional cirrhosis.*

Case 561: Presented by Dr. Uriel Garcia, Cincinnati General Hospital.

A 34 year old white woman was hospitalized with a cough of ten years duration. Sputum was yellowish green and amounted to one cup a day. She had been hospitalized for hemoptysis eight years ago. Chest x-ray revealed fibrotic strands and areas of cavitation in the right upper lobe. Bronchial washings were negative for A. F. B.

and tumor cells. Bronchoscopy revealed purulent secretion from the right upper lobe bronchus.

A right upper lobe lobectomy was done. The specimen showed cystic bronchiectasis. At the lower end of the lobe, two bulging nodules, each about 1.5 cm., protruded into a terminal cystic bronchus. Fine hair was noted over these nodules. A solid and cystic lesion was attached to the anterior medial aspect of the right upper lobe. The cystic portion communicated with a dilated tortuous bronchus. At the time of surgery, it could not be definitely determined whether the lesion arose in the anterior mediastinum or whether it arose in the lung.

Microscopically, the cystic portion was lined with squamous epithelium of a cutaneous type, beneath which various skin adnexal elements could be identified. A variety of tissues were identified in the solid portion, including pancreatic tissue containing islands of Langerhans.

Diagnosis: *Adult teratoma involving bronchus.*

Case 562: Presented by Dr. Bernard Black-Schaffer, Cincinnati General Hospital.

A 17 year old colored girl entered the hospital January 4, 1954, with pneumonia of both lower lobes. Treatment consisted of penicillin and terramycin.® Temperature was normal after four days. On January 11, the chest films showed incomplete resolution of the process on the left but considerable infiltrate remained on the right. The pneumonia recurred three times in the ensuing nine months, and at no time was complete clearing of the right middle lobe evident on chest films. A variety of organisms was recovered from the sputum at different times, but studies for tubercle bacilli were negative. Following biopsy, a right middle lobe lobectomy was planned. During the induction of anesthesia cardiac arrest occurred. Cardiac massage reinstated heart beats but the patient expired the following day.

Autopsy showed an encircling sessile, yellowish-gray protuberance in the right middle lobe bronchus near its origin.

The tumor which encircled the middle lobe bronchus was composed of polyhedral cells with granular acidophilic cytoplasm. The nuclei were small, dark staining and uniform. The tumor cells surrounded the normal structures of the bronchus, including the glands and cartilage, but did not destroy any of these.

Diagnosis: *Granular cell myoblastoma of the bronchus.*

Case 563: Presented by Dr. William T. Collins, Good Samaritan Hospital, Cincinnati, Ohio.

A 16 year old white boy entered the hospital October 22, 1954, with pains in the legs. Five weeks previously he had fallen from a horse and the leg pain began shortly thereafter. Later the sternum and costochondral junctions became prominent, and the patient complained of chest pain. On physical examination, the legs, including the joints, were normal. The hemoglobin was 8 Gm. The white cell count was 2,750 with 60 per cent lymphocytes. The red cells showed anisocytosis, poikilocytosis and polychromasia. Serum calcium was 13 mgm. per 100 cc., phosphorous 7 mgm. per 100 cc., and alkaline phosphatase 33 units. Bone x-rays showed nodular and coalescent osteoblastic and osteoclastic lesions involving the entire skeleton, no area differing significantly from any other. Patchy densities extended from both lung hila into the peripheral fields.

The patient lost ground steadily. Nitrogen

mustard was without effect. Fever to 104°F. did not respond to penicillin. Severe dyspnea ensued, and hard nodules appeared in the skin. Purpura appeared, dyspnea became more severe, and finally there was hematemesis. The patient expired December 5, 1954. At autopsy the lungs showed diffuse calcification and fine "honeycomb" appearance.

Throughout the lung, but particularly in the vicinity of blood vessels and bronchi, was a rather cellular fibrous tissue within which could be identified anaplastic osteoblasts and osteoid tissue undergoing calcification. All tissues examined at autopsy showed similar involvement. All bones were dense, showed no gross evidence of hemopoietic foci, and microscopically showed tissues similar to that invading the lung.

Diagnosis: *Osteogenic sarcoma metastatic to lung.*

Case 564: Presented by Dr. David G. Freiman, Cincinnati General Hospital.

A 60 year old white bartender was admitted to the hospital in an unresponsive and lethargic state. On admission temperature was 98°F., pulse 120 and irregular, and blood pressure 120/70. The heart was enlarged. Cranial nerves were intact, plantar signs normal, and peripheral muscles weak. Laboratory studies revealed hemoglobin 14.5 Gm., red blood count 6 million, and white blood count 7,400 with normal differential. Urine had a specific gravity of 1.012 and 4 plus albumin. Blood urea nitrogen was 62 mgm. per 100 cc. Total protein was 6.35 per cent (albumin 2.7 per cent). Ascites were noted on x-ray. An electrocardiogram showed auricular fibrillation and nonspecific myocardial damage. Temperature rose to 105°F. He expired on the eighth hospital day.

At autopsy a 3.5 cm. hemorrhagic nodule was noted at the lower pole of the right thyroid lobe. The liver was moderately cirrhotic. The lung appeared severely edematous.

Sections of the lung showed extensive calcification of the alveolar walls and the walls of the blood vessels. Many of the blood vessels showed a mixed cellular infiltrate involving all coats of the thickened intima. The nodule at the lower pole of the right lobe of the thyroid was a chief cell parathyroid adenoma. Sections of bone showed a typical picture of osteitis fibrosis cystica.

Diagnosis: *Metastatic pulmonary calcification associated with parathyroid hormone intoxication.*

Case 565: Presented by Dr. Herbert Braunstein, U. S. Veteran's Hospital, Cincinnati, Ohio.

A four months' old male cocker spaniel showed mild cyanosis and enlargement of the heart. Because of severe disability the animal was sacrificed. The heart was moderately hypertrophied. Both the ductus arteriosus and the foramen ovale were widely patent. The lungs showed tiny 1 to 2 mm. gray white nodules on the surface and in the parenchyma. Sections of the lung showed inflammation of the walls of small arteries and arterioles. A few vessels showed fibrinoid necrosis. The infiltrate was of variable composition. Occasional vessels showed occlusion by endothelial proliferation.

Diagnosis: *Pulmonary peri-arteritis nodosa.*

Case 566: Presented by Dr. J. P. Wozencraft, Cincinnati General Hospital.

A 17 year old white housewife was hospitalized for the first time on January 4, 1955, with epi-

staxis. She had had repeated nosebleeds for one year, the last one continuing for 48 hours. Physical examination revealed obstruction of the right nostril by a grayish mass and purulent exudate. The septum was deviated to the left. Following a biopsy on January 26, 1955, complete removal of the intranasal tumor was carried out. The lesion was said to be attached to the floor of the lateral wall of the nose.

A polypoid mass had a fibrous stroma showing a mixed cellular infiltrate. Within this stroma were scattered small nests of cells. These cells were small and had small, dark, round nuclei. From occasional nests, the cells streamed out into the surrounding stroma forming cords a single cell thick. Between these cords were fine fibrills.

Diagnosis *Aesthesioneuroblastoma (olfactory neurocytoma)*.

Case 567: Presented by Dr. Herbert Braunstein, U. S. Veterans Hospital.

A 48 year old white bus driver was hospitalized because of sore hands. He gave a history of having handled paraffin as a candle maker many years ago. Four years prior to hospitalization the dorsa of his hands broke out with small blisters. Local treatment produced partial remission. A few months ago the skin began to scale and small nodules appeared.

Physical examination revealed irregular hyperkeratotic and hyperpigmented plaques with marked scaling on the dorsal aspect of both hands. The left hand showed, in addition, a papillomatous nodule approximately 2 cm. in diameter with a rough surface. The nodule was widely excised.

The lesion was composed predominately of irregularly disposed, anaplastic, spindle cells. In a few areas deep within the tumor were found small islands of anaplastic squamous cells which occasionally formed keratotic pearls. Changes of preinvasive carcinoma were seen in the superficial epithelium. In a few areas anaplastic squamous cells extended from the deep epithelial nests or from the neoplastic superficial epithelium to blend imperceptibly into the spindle cells which formed the main component of the tumor.

Diagnosis: *Squamous cell carcinoma and fibrosarcoma*.

Case 568: Presented by Dr. William T. Collins, Good Samaritan Hospital.

A 39 year old white man was in good health until 10 years ago when he was hospitalized for "nephritis." He had pyuria and hematuria on several occasions. In December 1954, he had left flank pain, fever, chills and cloudy urine. The only pertinent physical finding was left upper quadrant tenderness. Urine specific gravity was 1.014, and the test for albumin was positive. There were white blood cells and granular casts in the sediment. Bladder trigonitis was observed on cystoscopy. Retrograde pyelography showed multicystic cavities continuous with the calyces of the left kidney. The right kidney was normal. A left nephrectomy was done on January 7, 1955.

This case was previously presented during the Scientific Program and showed numerous cysts involving predominately the renal pyramids. The cysts were lined with cuboidal to low columnar cells.

Diagnosis: *Cystic disease of renal pyramids*.

Franklin County Pelvic Cancer Delay Committee Report

By JOHN H. HOLZAEFFEL, M. D.

Columbus, Ohio, Chairman

The Franklin County Pelvic Cancer Delay Committee met at 12 o'clock noon on February 15, 1956, at the Columbus Health Center. Three cases were presented.

Case 15: A 32 year old white female who desired reduction diet in April, 1955. Cervix was checked and specimen for biopsy taken as part of complete physical examination. The patient was advised to enter the hospital for more extensive biopsy. For financial reasons she delayed two months. The original biopsy specimen was not sent to a pathology laboratory. On June 26, 1955, biopsy of the cervix revealed epithelioma, Grade II, Clinical Stage I. Treatment: 4220 mgm. hours of radium and 2600 r. in air. Examination six months later: vaginal stenosis, Papanicolaou smear negative.

Comment: *Dr. Fred Hapke*: Original biopsy specimen should have been sent in. Smear at that time would have aided in clarifying the diagnosis. There was two months' patient delay, but part of the responsibility was the physician's.

Case 16: In 1948 this patient was 45 years old. Examination was negative. In April, 1951, pelvic examination revealed uterine fibroids. Papanicolaou smear taken then was negative. Since the diagnosis was uterine fibroids, definitive surgery was deferred until June, 1951. Right ovarian adenocarcinoma and left ovary were removed. In June, 1955, smear was negative. In December, 1955, patient had vaginal bleeding. A dilatation and curettage was done, diagnosis of adenocarcinoma of endometrium. Smear at that time revealed malignant cells. Treatment consisted of 6000 mgm. hours of radium intrauterine, to be followed by hysterectomy.

Comments: *Dr. Robert Inglis*: A hysterectomy should probably have been done at the time of oophorectomy in 1951.

Dr. William Copeland: A dilatation and curettage of the uterus and biopsy of the cervix should have been done prior to the oophorectomy.

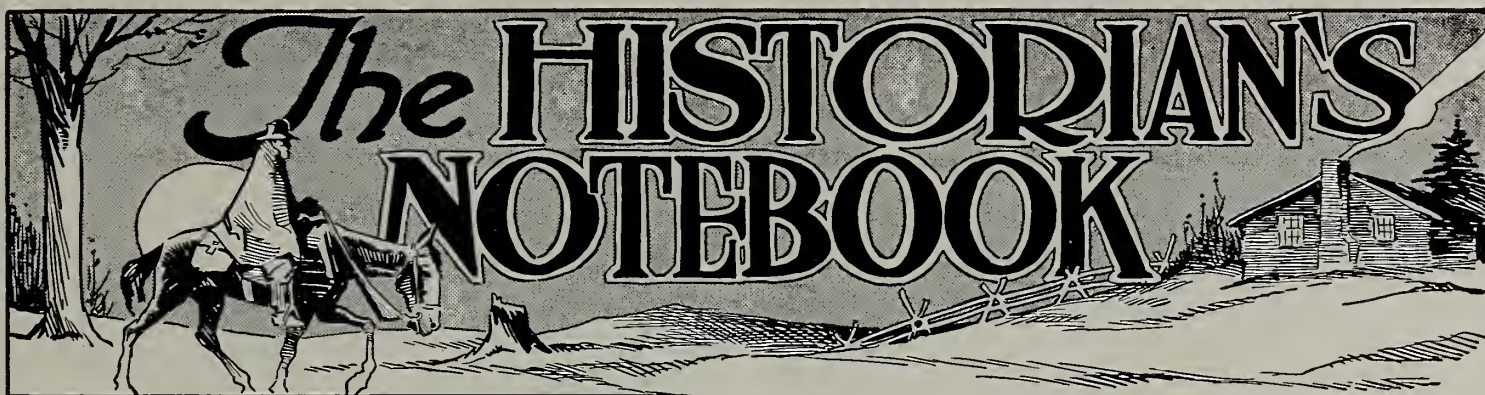
Dr. Fred Hapke: At the time of the first examination in 1948, the patient was 45 years old and through the menopause with a normal pelvis. Fibroids do not generally enlarge postmenopausally unless they are malignant. Ovarian carcinoma should have been considered.

Case 17: A 62 year old white female who was seen in June, 1955, due to vaginal bleeding. Senile vaginitis diagnosed; Papanicolaou smear was negative. Cervix was clean. In October the smear was negative. Because of her concern and a persistent discharge the patient was admitted for a diagnostic dilatation and curettage. The endometrial cavity was nearly filled with carcinoma.

Comments: *Dr. William Copeland*: This patient's insistence was a prime factor in bringing her to surgery. The Papanicolaou smear gave false assurance.

Dr. Franklin Hugenberger: Postmenopausal vaginal discharge in increasing amounts is a warning sign.

Dr. John Holzaepfel: There's no delay here—just great good fortune.



Rise and Decline of Freudianism

MAX SEROG, M. D.

PART II

(Concluded from April Issue)

JUNG

JUNG, too, did contribute much to psychotherapy through new psychological insight. The prolonged reaction time in association experiments of affective complexes, the similarity of schizophrenic thinking and dream thinking may be mentioned here. Jung's modifications of Freud's concept are rather deep, but they are still built upon the brittle foundation of the psychoanalytic theory. The "unconscious" is here expanded to a collective unconscious and becomes still more nebulous than the unconscious in Freud's concept. However, Jung's idea that there are in each individual some mental tendencies and attitudes, yes, some mental contents inherited as properties of the race, have a base in facts. When we disregard the theory constructed for the interpretation of these facts, and when we ignore the connotations of these phenomena as "unconscious," we may find that what Jung calls the "Collective Unconscious" or "Archaic Collective Contents" is closely related to primitive thinking. "The archetypical thinking" is the archaic primitive, synthetic thinking, which does not proceed to abstraction through logical delineation, but which comprehends world and life as still unbroken "emotional totality" (Serog). It is closely related to the dream thinking, to the thinking of small children, to the schizophrenic thinking; it is the basis of psychic understanding and the root of imagination and intuition (Serog).

WILHELM STEKEL'S FINAL INSIGHT

Another of the rebels was Wilhelm Stekel. His theory was in many respects still more arbitrary and more objectionable than Freud's concept. But Stekel was one of the outstanding

The Author

- Dr. Serog, Dayton, is a member of the staff of the Dayton State Hospital.

and most successful psychotherapists among the psychoanalysts. His prominence in the art of dream interpretation was unrivaled; it was recognized even by Freud in spite of his personal antagonism. The striking difference between the far-fetched constructions in Stekel's book and his psychotherapeutic accomplishments is still more marked than the disproportionality between Freud's writings and his psychotherapeutic activities, proving again that psychotherapeutic theory and psychotherapeutic efficiency have not much to do with each other.

But in Stekel's case psychotherapeutic experience won a victory over constructed theory. In his preface of his *Technique of Analytic Psychotherapy* Stekel wrote: "After 30 years' experience of analysis I no longer believe in the overwhelming significance of the unconscious . . . Such analysts fail to recognize the nature of the spiritual conflict, from which the patient suffers . . . The discovery of all these things is work for an intuitive artist, endowed with imaginative insight . . . Orthodox Freudian analysis will not endure . . . A science in which the Master's utterances have become dogma is more of the nature of religion or sectarianism than of science and is doomed to destruction . . . The medical analyses of tomorrow will have to establish an undogmatic, unprejudiced psychoanalysis."

Through the psychoanalytic societies Freud's doctrine was propagandized and spread to other

Submitted September 13, 1955.

countries. However, only the Anglo-Saxon countries proved to be really responsive. "France," says Freud, "has shown herself the least responsive to psychoanalysis." "In Germany" (which refers to pre-Nazi Germany) "psychoanalysis is the main topic of all scientific discussions and evokes from the laity as well as from physicians opinions of decided rejection, which are constantly renewed and strengthened." The flat skeptical rejection of psychoanalysis in France and its thorough dismembering disapproval in Germany are significant for the mentality of both countries.

SLOW DECAY

In the psychoanalytic therapy some progress was made (Ferenczi, Alexander). The rigid orthodox technique was replaced by a more flexible and more active procedure. Besides the analysis of symptoms, an analysis of character and personality was developed. The psychoanalytic doctrine remained taboo. Not earlier than in recent years some psychoanalysts grew more critical against Freud's basic assumptions, if not as yet against his concept. Even so, today Freud's structure is no longer the magic entity of yesterday. Clefs and fissures appear everywhere. The "Goetterdaemmerung" of Freud's theory has started. Goetterdaemmerung is not always a spectacular performance. Slow decay destroys more thoroughly than dramatic vanishing.

However, when finally the deluge of psychoanalysis should occur, we should take care lest together with the worthless psychoanalytic theory the valuable psychoanalytic therapy is washed away. For psychoanalysis is not only a theory, objectionable from logical, psychological and methodological viewpoints, it also is a therapy which involves useful psychotherapeutic ideas and which represents a valuable psychotherapeutic attitude and an adequate psychotherapeutic approach. But the effects and results of the therapy are independent of the theory.

The belief that psychoanalytic therapy is but applied psychoanalytic theory is a Freudian myth, which was the more believed, the more time had elapsed since the beginning of psychoanalysis. Historically, the therapy preceded the theory. Not earlier than after his therapeutic successes did Freud create his theory to render account for his psychotherapeutic results. Through the psychoanalytic interpretation of his technique, of his results and of his observations, Freud created the dogma that the results of the therapy prove the correctness of the theory. In the beginning of psychoanalysis when the true connections were still more noticeable they were clearly seen by some of Freud's critics.

As early as 1917 Woodworth objected to the attempt to prove the theory through the therapy: "Nor can the success of the treatment be used as weighty evidence in favor of the theory. If the psychoanalytic treatment could be rigidly

deduced from the Freudian theory . . . or even if the practice had originated as a deduction from the theory this argument would have weight. As a matter of history, however, the treatment grew up first and the theory was then developed as a sort of rationalization of the treatment."

Even if still spellbound in the magic circle of Freud's doctrine, psychoanalysts increasingly became aware of the contradictions between the theory they believe in and their experiences in their daily psychotherapeutic work.

In *The Handbook of Dreamanalysis* Gutheil arrives at a strong criticism of Freud's dream theory. He shows how Freud's dream theory makes him blind for conspicuous facts and how Freud's theory results in far-fetched and absurd dream interpretations. Dream interpretation, according to Gutheil, cannot be based on a theory at all; it cannot be done merely logically, it remains to a great deal a matter of experience and intuition.

Karen Horney, in her book, *New Ways of Psychoanalysis*, shows the impossibility of some of Freud's sex concepts; she replaces Freud's over-generalized and over-simplified sex theory with a generalized and simplified social theory. Objections against this attitude were raised by sociologists (Green).

Karen Horney questions the dogmatic groundwork of the psychoanalytic theory as no follower of Freud had done before. However, she intends only to criticize and to modify, not to destroy Freud's doctrine. But in an artificial structure where one brick backs the other one, and the pillars are designed to carry the whole, you cannot remove a supporting beam, not to speak of a pillar, without demolishing the whole structure. Mere alterations and modifications are useless when the foundations are brittle. No patching of single parts can do the job. The new ways in psychoanalysis lead outside, not inside, of the psychoanalytic theory.

FRENCH AND ALEXANDER

The book, *Psychoanalytic Therapy*, by Thomas French and Franz Alexander, published in 1947, represents a principal break with the traditional Freudian approach to psychotherapy. "The procedure is modified to conform to the varying needs of the individual patient and to the different phases of the treatment." Such principles, although revolutionary in psychoanalysis, are as old as psychotherapy. Alexander proclaims: "The choice of the particular method should be determined by the nature of the therapeutic problems." This psychotherapeutic maxim has long been familiar to all true psychotherapists, even more to the non-psychoanalytic ones.

It was emphasized by me in papers and lectures 40 years ago; it was proclaimed and published at this time by a group of German psychoanalytic terminology. But such basic psy-

and I. H. Schultz, who, although never organized, had a similar psychotherapeutic attitude. Times have changed again, the magic Freudian spell seems to be broken. But still the Freudian label sticks and, with it, its unnecessary psychoanalytic accessories and the disputable, often misleading psychoanalytic terminology. But such basic psychotherapeutic principles as stressed in the book of French and Alexander do not need the Freudian label. It sticks to them inconsistently and by no other justification than emotional tradition and custom. But, it is a custom "more honored by the break than the observance."

With the book of French and Alexander, psychotherapy, no longer mistaken as applied psychoanalytic theory, comes again into its own. A longer development in this direction, we may hope, will lead to the emancipation of the psychoanalytic therapy from the psychoanalytic theory. Their true psychotherapeutic attitude has led French and Alexander outside of Freud's concept. Their book is a document of the victory of psychotherapy over psychoanalysis. However, the authors still tend to appear in the traditional framework of psychoanalysis. If their new attitude is something of a revolution, it certainly is a quiet revolution.

FREUD'S PARADOX

The book of the French psychoanalyst Madeleine Cavé, *L'œuvre Paradoxale de Freud* ("Freud's Paradoxical Work") is a vociferous and aggressive revolution. Cavé emphasizes "the paradoxical antagonism which exists between Freud's indisputable clinical discoveries and the books which should render account of them."* Freud's clinical discoveries are of high value, his books worthless. This fact, according to Cavé, is the reason why outstanding scientists have so contradictory an opinion of Freud's work. Some judge Freud by his books, others by his clinical results. "Contrary to all anticipation," says Cavé, "one cannot judge the immense value of his achievements from the confused mediocrity of his writings." In spite of many exaggerations in Cavé's book, her main idea is true.

If you just look upon Freud's writings about psychoanalysis from a logical or scientific viewpoint they are valueless. But when you work yourself with analytic methods you come to appreciate Freud's work and his achievements. They rest not on logic and science, they rest on imaginative thinking and intuitive psychic understanding. Psychic understanding is the immediate interpretation of psychic motivations through emotional empathy. This cannot be explained logically like a scientific truth. Here, as in art, one must experience impressions in order to understand them.

Similar viewpoints had been expressed long ago by Bjerre, the follower of Freud. Bjerre

objects to Freud's "offending blunders"; and yet, along with it, Bjerre states that we need Freud's view from within in any psychotherapy we perform.

VALUE OF THE METHOD

He who saw psychoanalysis only from the outside, who knows only the dogmatic, illogical theory, may ask amazed how anything like that could ever be believed. But he who worked himself with the psychoanalytic method and learned its indications and contraindications may be surprised by its results. After more than 40 years of extensive psychotherapeutic experience with various psychotherapeutic methods, I think that the psychoanalytic method when employed in adequate cases with flexible technique is often superior to other methods. This, however, has, as mentioned frequently, nothing to do with the theory, but only with the method itself. More than other methods, it can be utilized as an impressive emotional experience for the patient. Analytic treatment more than any other psychotherapeutic method can become an effective instrument for the true psychotherapist as it brings into play all his psychotherapeutic qualities.

In the value of the therapy and the worthlessness of the theory, the double face of psychoanalysis and its basic inconsistencies become apparent. The basic inconsistency in Freud's work is the inconsistency between imaginative psychic understanding of psychic motivations and connections and the illogical structure of a rationalized theory, impressive in its facade, but worthless in its structure and content.

The value of Freud's work does not rest in his pseudo-scientific theory. Freud's genius appears in his approach from within, in his understanding attitude, and in his methods he created to make this approach and his attitude fruitful for psychotherapy. Principles and methods of the psychoanalytic therapy will stay as a true enrichment of psychotherapy. However, Freudianism as a doctrine is on the decline. We should not mourn it. We cannot speak here of all its obnoxious consequences; we cannot discuss how it interferes with the progress of psychiatry. For in psychiatry we interpret with Freudian terms before we know what to interpret. We look for interpretations, instead of for facts. We put the cart before the horse.

The fortress of Freud's theory is crumbling. People outside of it begin to sense its fate. But the crew within seems not to be aware of what's going on. The pillboxes, one after another, are surrounded, and yet they still behave as if their fortress is unassailable. Freud's doctrine is losing its unity, the source of its strength. Freud's unifying leadership has vanished. Freud's empire is falling apart. The generals take over.

The present situation of Freud's doctrine is labile. It cannot stay this way for long. Its further decline is inevitable. The structure which

*The translations from the French are mine. (Serog)

Freud created was not built for eternity, as he imagined. But even then, when his theory will be only a matter of history, Freud will remain one of the greatest psychotherapists.

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Research in the Pharmaceutical Industry

No one knows when studies of drugs began. The aborigine accidentally discovered that some plants and extracts made from them had certain specific physiological effects in human beings. Later, in the middle ages, some of the more imaginative alchemists, apothecaries, and physicians—like Paracelsus—got the glimmering of the idea that to make an effective drug was a nobler object than to transmute base metals into gold.—Ernest H. Volwiler, Ph. D., North Chicago, Illinois: *South Dakota J. Med. & Pharm.*, 9:116, March, 1956.

Dr. Frederick C. Waite Formerly Of Cleveland Is Dead

Readers of the Historian's Notebook will be saddened at notice of the death of Frederick Clayton Waite, Ph. D., a frequent contributor to these columns over a period of many years. Dr. Waite died March 30 at his home in Dover, New Hampshire, at the age of 86.

In 1940 Dr. Waite retired from the Western Reserve University Schools of Medicine and Dentistry with the title of emeritus professor of histologic anatomy. He had taught histology and embryology at the schools from 1901 to 1940 and was the founder of the Department of Histology and Embryology. His contributions to medical literature consist of numerous books and articles.

Early Views Regarding The Daily Bath

Queen Isabella boasted that she never had but two baths; one at birth and one at marriage. The Puritans thought it "an unseemly and dangerous piece of foolishness, especially harmful in cold weather" to take a bath.

Lack of privacy, inconvenience, limited water facilities and the formal dress of the day made it customary to wash daily only those exposed parts and at times the feet. Large amounts of toilet water was used instead of water. Napoleon used 60 bottles of Eau de Cologne each month. Washington and La Fayette were both addicted to the use of toilet water and considered Florida water the "richest of all perfumes."

In 1840 Mrs. Lydia E. Pinkham went so far as to endorse the daily bath and it was said that "if Mrs. Pinkham stated it was perfectly safe to take baths summer and winter, even a nervous family would be inclined to try it."

Asclepiades, His Life and Writings, by Robert M. Green, M. D., (\$6.00. *Elizabeth Licht, Publishing Company, New Haven, Conn.*). This is a translation of Cocchi's Life of Asclepiades and Gempert's Fragments of Asclepiades. He was the most important physician between Hippocrates and Galen, the first to associate hydrophobia with the bite of rabid animals. He advocated exercise, especially walking in hot sands for paralysis of the lower extremities, also steam baths and massage. In the field of mental disease and occupational therapy, his ideas were advanced. He made specific prescriptions of music for the mentally ill. This book makes Asclepiades available to many for the first time in more than a century. We must recall that it was Asclepiades who as the founder of the Methodist sect summed up and transmitted the methods which were later put to such great use by Galen.

Polio Vaccine . . .

Single Shot Schedule Is Recommended by Health Department with an Increase in Priority Age Limit; More Vaccine Is Coming into Ohio

TWO important developments in the poliomyelitis vaccine program in Ohio have been announced since the report was written for last month's issue of *The Journal*:

(1) Dr. Ralph E. Dwork, director of the Ohio Department of Health, has recommended, as long as the supply is limited, that a single inoculation be given to children in the priority age group 1 through 10, and that, if there is a surplus from the first priority group, a single shot be given to children 11 through 15 years and pregnant women.

(2) Nearly 400,000 cc. of vaccine have been allotted to Ohio in the period from March 20 through April 18, a considerable increase over previous monthly allotments.

STATEMENT

Following is the complete statement issued by Dr. Dwork in announcing the single-shot recommendations:

"Due to the continuing short supply of poliomyelitis vaccine and to the imminence of the 1956 poliomyelitis season it is felt advisable to suggest certain modifications of the previously recommended inoculation schedule.

"Although it is still the consensus of informed opinion that two inoculations of vaccine are necessary for optional protection, it is now clear from the analysis of the experiences of the summer of 1955 that one inoculation will offer protection in 50 to 75 per cent of children inoculated. This being the case the question arises as to whether the presently available supply of vaccine, which represents but 50 per cent of Ohio's need, should be used for one inoculation in as many children as possible with the hope of obtaining 50 to 75 per cent protection in this group, or whether the supply should be used for two inoculations in a smaller group with the hope of attaining the maximal 80 to 90 per cent protection.

"There is reason to believe that vaccine production and release rates are increasing and that if the presently available supply were used for one inoculation in as many children as possible, enough vaccine will become available during the summer to give these children the second inoculation. It has, therefore, been concluded by this Department, that maximum benefit in terms of paralytic poliomyelitis prevention may be obtained by utilizing the present supply of vaccine for first inoculations only without saving any for second injections. Subsequent supplies, as they become available, may be used to complete the inoculations.

"In areas where public agency vaccine has not yet been distributed, it is suggested that the vaccine be used for first inoculations in children age one through fifteen years and pregnant women. The age group one through ten should still receive first priority. However, since the amount distributed to each local area has been calculated on the basis of two inoculations for eligible children one through ten, if one inoculation were given these children the local supply would be in excess of the demand in this age group and could then be used in the age group eleven through fifteen. As soon as all local areas have received initial supplies of vaccine to begin their program, areas which have already completed two inoculations in the one through ten age groups, may use subsequently received supplies for first inoculations in the eleven through fifteen age group and pregnant women.

AUTHENTIC SOURCES

"The decisions expressed in this memorandum have been arrived at after consideration of information received from authoritative sources available to this department. It should be stressed however, that medically oriented individuals will differ in interpretations of existing data.

"It is our opinion that the above outlined use of the vaccine will yield the maximum amount of protection from existing supplies. However, this memorandum should be considered a suggested flexible method of operation and the decision as to whether or not it will be used should be that of the local health commissioner and attending physicians. The Ohio State Medical Association will be notifying local medical societies of the suggested modifications so that practicing physicians will feel free to use commercially available vaccine for first inoculations in the expanded age group.

"Since the presently outlined schedule implies the use of vaccine through the poliomyelitis season, it should be emphasized that the Federal Poliomyelitis Vaccine Advisory Committee to the Public Health Service, has strongly recommended that inoculations of poliomyelitis vaccine be continued through the poliomyelitis season. A very small possible risk is greatly outweighed by the advantages of protection.

"Investigation concerning the third inoculation is still under way and plans for its administration should be held in abeyance until the unprotected population have had their first and second inoculations. More information on this

subject will be forwarded to you just as quickly as it becomes available."

RECENT ALLOTMENT RECEIVED

Dr. Dwork reported that the following allotments of vaccine had been received by the Ohio Department in the period from March 20 through April 18 and that it had been distributed as indicated:

March 21— 53,082 cc. all distributed to commercial channels

March 27— 44,298 cc. all to commercial channels

March 31—108,990 cc. 30,006 cc. purchased for public agency distribution and 78,984 to commercial channels

March 31— 26,046 cc. all to commercial channels

April 6— 49,023 cc. all public agency distribution

April 6— 36,567 cc. all public agency distribution

April 11— 45,603 cc. all commercial

April 17— 35,307 cc. all commercial

Total 398,916 cc. of which 283,320 cc. went into commercial channels and 115,596 cc. were purchased for agency distribution.

That makes a total of 1,602,214 cc. received in Ohio from August 1955 through April 18, of which 985,789 cc. have gone into commercial channels and 616,425 cc. purchased for agency distribution.

STATEMENT ON COLOR VARIATIONS

The following direct quotation of a statement by Eli Lilly and Company was distributed by Dr. Dwork to local health commissioners in Ohio:

"Should you be questioned about the color of Poliomyelitis Vaccine, Lilly, bearing lot numbers 663615 or 663616, please assure your physicians that the vaccine is entirely satisfactory for use from the standpoint of both antigenicity and safety. Most of this material has been sent out from Indianapolis and the balance is being readied for shipment. Vaccine carrying the aforementioned lot numbers has a very pale yellow or pale yellow-amber color rather than the pink cast of previous lots.

"As reported in earlier issues of the *Newsletter*, phenol red is used as an indicator in the production of polio vaccine. This indicator is very sensitive to slight changes in pH and other chemical phenomena, neither of which has any untoward effect on the potency and safety of Poliomyelitis Vaccine, Lilly, that has been or will be supplied to the medical profession. In addition to the stringent control and testing procedures given the vaccine by your Indianapolis associates, each lot is subject to testing and must be approved by the National Institutes of Health. Of course, the

lots of vaccine referred to here have been carefully examined and carry the approval of both of these groups.

"Because of the characteristics and behavior of phenol red, vaccine released in the future may exhibit some color variations from lot to lot. Continuing studies are directed toward the possibility of eventually eliminating this indicator from the vaccine."

Practical Nurse Association Plans Series of Refresher Courses

An approved Refresher Course, designed to prepare experienced practical nurses for examination for state licenses, and to give better patient care, is being made available throughout Ohio through the efforts of the Practical Nurse Association of Ohio, Inc. The organization is urging experienced practical nurses to avail themselves of the opportunity of license by examination—available for the first time under amended Substitute Senate Bill No. 177, which became effective in Ohio on January 1, 1956—and is presenting an educational program which will assist those deserving to qualify for a license.

The education being offered by the PNAO, Inc., with the co-operation of area hospitals in several cities, is the "Extension Course in Practical Nursing," a 64-hour course for the experienced practical nurse. This program has the approval of the National Association for Practical Nurse Education, a national accrediting agency.

The refresher course will be offered in those hospitals willing to cooperate in this movement. Classes will be given in the evenings, twice a week, with 3-hour sessions. Instructors must be registered nurses with teaching experience in nursing arts. The course will be scheduled in various cities, according to the demand as reflected by applications in the area.

Cooperation of the County Medical Societies throughout Ohio, and of hospitals in cities where this program has not already been introduced, is being sought by the Practical Nurse Association of Ohio. Information also will be welcomed concerning persons in any area in a position to assist with the Association's objectives as class instructors.

It is the aim of the Practical Nurse group to extend this program to all areas in the State where no form of recognized education previously has been offered to the practical nurse of experience. Interest is concentrated at the present time on rural areas, as the Practical Nurse Association has received a grant for that purpose.

Those interested in this program of education may obtain further information about details from the Practical Nurse Association's main office. All communications and applications should be addressed to: Practical Nurse Association of Ohio, Mrs. M. Kuhlmann, Education Chairman, Bancroft Hotel, Springfield, Ohio.

P.G. Services in Anesthesiology . . .

OSMA Cooperating in Teaching Program To Meet Needs of Physicians and To Increase Number Better Qualified To Render Services in This Field

By JAY JACOBY, M. D.

AN increasing amount of interest in anesthesiology has been developing for some time among physicians in general practice. Several factors are responsible for this, most important being the desire of the physicians to provide better and safer anesthesia service to the patients in their communities.

The ease and speed with which anesthesia can be produced by the newer drugs at first led to the belief that anesthesia was becoming simpler and safer. Many physicians and surgeons learned that the ease of administration did not mean an increase in safety, and that the difficulties encountered in anesthesia may occur with the new drugs as well as with the old. In fact, the difficulties arise more swiftly and are even more serious when the newer drugs are used.

MUST KNOW HOW

The experiences which many physicians had during the war taught them that anesthesia could be made more safe, more pleasant for the patient, and more suitable for the surgeon, if the anesthesiologist had at his command not only the new drugs but, more important, a better knowledge of how to use them.

At the present time in many communities, anesthetics are administered by physicians with little or no special training. Some limit themselves to one or two drugs or methods with which they have had fairly extensive experience, and in the use of which they have become very proficient. Others have attempted to utilize the newer drugs, but have had inadequate training in their administration and in the management of the complications which may arise.

TEACHING PROGRAM STARTED

A desire for more training in anesthesiology has been indicated by a large number of physi-

cians who now administer anesthetics in their own communities. Other physicians in general practice want to learn anesthesiology so that they may render this service to the patients in their communities.

Because of these requests, and because an inadequate number of physicians is now available to administer anesthetics, a teaching program has been undertaken under the auspices of the American Society of Anesthesiologists, the Ohio Society of Anesthesiologists, and the Committee on Maternal Health of the Ohio State Medical Association. The aim of this teaching program is to provide larger numbers of better trained physicians to administer anesthesia for both surgical and obstetrical patients.

OPPORTUNITIES AVAILABLE

The educational opportunities available to the physicians of this state are varied, so that every interested physician can find a teaching program which suits his needs.

(1) County medical society and hospital staff meetings may be addressed by anesthesiologists on particular phases of anesthesiology which are of interest to the groups.

(2) The Ohio Society of Anesthesiologists meets twice each year, and the Section on Anesthesiology of the Ohio State Medical Association meets yearly. These meetings are open to all interested physicians, whether or not they are members of the organizations. The subject matter is designed to be of specific and practical interest to physicians who administer anesthetics.

REGULAR MEETINGS SCHEDULED

(3) The teaching hospitals of the state, and the anesthesia societies in the larger communities, have regularly scheduled meetings for the presentation of appropriate topics of interest to the

THIS article was written by Dr. Jacoby, director of anesthesia, Ohio State University College of Medicine, at the request of the Committee on Maternal Health, Ohio State Medical Association. The committee, realizing the need for a larger number of physicians with more adequate training in the administration of anesthesia and in the management of complications which may arise, urged cooperation by the OSMA in a teaching program in Ohio in this field. The suggestion was approved by The Council of the Ohio State Medical Association. The article by Dr. Jacoby outlines the aims of the teaching program and lists the existing opportunities in Ohio available to physicians wishing special or refresher work in anesthesiology.

anesthesiologist. In most instances these meetings are open to all physicians.

(4) Refresher Courses in anesthesiology are now being offered at The Ohio State University and Western Reserve University. These courses will be given several times each year; they consist of observation in the operating rooms of the University Hospitals and attendance at Lectures and seminars on subjects of interest to the group.

PRECEPTORSHIP-TYPE TRAINING

(5) Practical, clinical training is available to physicians who wish to improve or perfect their techniques in anesthesia. For this purpose it is not necessary for each physician to apply to the major teaching hospitals for an appointment. On the contrary, arrangements have been made with a number of qualified anesthesiologists in the state of Ohio to give individual preceptorship type training to interested individuals. This training is tailored to meet the needs and the desires of the individuals. The subject matter, duration, and intensity of the training are arranged between teacher and student. There is no formal program of required work.

REGULAR RESIDENCIES

(6) For those physicians who wish to specialize in anesthesiology, there are eleven hospitals in the state of Ohio where residency training in this specialty is available.

Canton, Mercy Hospital; Cincinnati, Christ Hospital; Cleveland, City Hospital; Cleveland Clinic Hospital; Huron Road Hospital; Mt. Sinai Hospital; St. Luke's Hospital; Western Reserve University Hospitals; Columbus, University Hospitals; Garfield Heights, Marymount Hospital; Youngstown, Youngstown Hospital.

BOOKLET AVAILABLE

The American Society of Anesthesiologists has prepared a booklet "Postgraduate Education in Anesthesia" describing training opportunities throughout the country. For information as to any phase of the teaching program or for copies of the booklet, you are invited to write to Dr. Jay Jacoby, University Hospital, Columbus, Ohio, who is the coordinator of the teaching activities in this field.

It is our belief that by your participation in this program it will be possible to offer to the citizens of Ohio better and safer anesthesia service.

Youngstown Area Heart Association Announces Elected Officers

Dr. John A. Rogers, Youngstown, was elected President of the Youngstown Area Heart Association succeeding Dr. William H. Bunn at their Annual Meeting April 12. Howard A. Welch, Youngstown, was elected Chairman of the Board, and Dr. John Noll was elected Vice-President.

New Members of O. S. M. A.

The following are the names of the new members of the Ohio State Medical Association since March 1st, 1956. The list shows the county in which they are affiliated, city in which they are practicing, or temporary address in cases where physicians are taking postgraduate work.

CRAWFORD COUNTY

Chas. E. Skinner, Galion

CUYAHOGA COUNTY

Bernard Chojnacki, Brecksville
Dmytro Farion, Cleveland
Santo Galanti, Cleveland
Eugenia B. Graper, Cleveland
Stefan J. Harasymowicz, Cleveland
Francis J. Januszski, Cleveland
Nellie K. Juskenas, Cleveland
Steven Kovacs, Cleveland
Thomas N. MacKrell, Cleveland
Garnett B. Moneymaker, Cleveland
Benjamin Mc Lane Spock, Cleveland
John C. Starling, Cleveland

FRANKLIN COUNTY

Frederik S. Barends, Columbus
Bertha Bouroncle, Columbus
Chas. R. Quinn, Columbus
J. Lloyd Wilder, Worthington

GALLIA COUNTY

Walter S. Price, Gallipolis

HAMILTON COUNTY

Alan S. Freemond, Cincinnati
Alvan B. Judd, Cincinnati
Milton Virshup, Cincinnati

HENRY COUNTY

Wilson J. Stough, McClure

LAKE COUNTY

Assen Oksiloff, Willowick

LORAIN COUNTY

Steven S. Bader, Amherst

LUCAS COUNTY

Burgess R. Bills, Sylvania
James L. Farkas, Toledo
Francis J. Flanagan, Toledo
Chas. D. Ford, Toledo
Harry H. Hollinger, Toledo
Bernard L. Huffman, Jr., Toledo
John R. Jones, Toledo
J. B. Sawyer, Toledo
Dana Ray Schmidt, Toledo
Guy W. Talmage, Toledo
Harold W. Wackenheim, Maumee
Leslie E. Whitmire, Toledo
Vytautas E. Zymantas, Toledo

MAHONING COUNTY

Ulrich H. Boening, Youngstown
Robert M. Foster, Youngstown

MONTGOMERY COUNTY

Lewis Booker, Dayton

PUTNAM COUNTY

Alphonse V. Armbruster, Ottawa

STARK COUNTY

Alfons Cecys, Louisville
Robie T. Childers, Jr., Massillon

TRUMBULL COUNTY

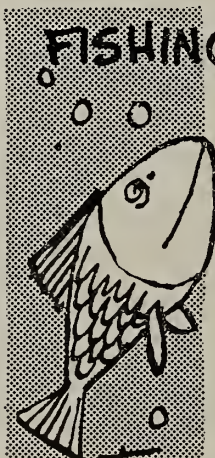
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HERE ARE RESULTS OF ELECTION AT ANNUAL MEETING IN CLEVELAND: DETAILED REPORTS IN JUNE ISSUE

Because of the limited time elapsed it was not possible to include in this issue of *The Journal* detailed reports of the 1956 Annual Meeting of the Association held in Cleveland, April 10-12. These reports with biographical sketches of newly elected officers, proceedings of the House of Delegates and other data will appear in the June issue.

So important, however, is the election of officers, Councilors and Delegates to the AMA that this information is announced.

New President is Dr. Richard L. Meiling, Columbus, succeeding Dr. Charles L. Hudson, Cleveland. Dr. Meiling has been serving as OSMA Treasurer. New President-Elect is Dr. Robert S. Martin, Zanesville, who has been Councilor of the Eighth District. Elected Eighth District Councilor to succeed Dr. Martin, is Dr. William D. Monger, Lancaster. Dr. Geo. J. Hamwi, Columbus, was elected treasurer.

Councilors re-elected for additional two-year terms are: Dr. C. T. Atkinson, Middletown, First District; Dr. James R. Jarvis, Van Wert, Third District; Dr. George W. Petznick, Cleveland, Fifth District; Dr. Robert E. Hopkins, Coshocton, Seventh District; Dr. C. L. Pitcher, Portsmouth, Ninth District; and Dr. H. T. Pease, Wadsworth, Eleventh District. Hold-over Councilors are: Dr. George A. Woodhouse, Pleasant Hill; Dr. Paul F. Orr, Perrysburg; Dr. C. A. Gustafson, Youngstown; Dr. Edwin H. Artman, Chillicothe.

AMA delegates and alternates elected for two-year term, starting Jan. 1, 1956, were Dr. Carl A. Lincke, Carrollton, delegate; Dr. H. M. Platter, Columbus, alternate; Dr. Charles L. Hudson, Cleveland, delegate, succeeding Dr. William M. Skipp, deceased; Dr. C. E. Hufford, Toledo, alternate; Dr. George A. Woodhouse, Pleasant Hill, delegate; Dr. R. Dean Dooley, Dayton, alternate; Dr. Herbert B. Wright, Cleveland, delegate; Dr. Fred W. Dixon, Cleveland, alternate. Hold-over delegates and alternates are: Dr. L. H. Schriver, Cincinnati, delegate; Dr. E. O. Swartz, Cincinnati, alternate; Dr. C. C. Sherburne, Columbus, delegate; Dr. Richard L. Meiling, Columbus, alternate; Dr. Carll S. Mundy, Toledo, delegate; Dr. Paul F. Orr, Perrysburg, alternate; Dr. Paul A. Davis, Akron, delegate; Dr. Edmund K. Yantes, Wilmington, alternate.

Psychosomatic Dermatology Emphasized at UC

Creation of a fellowship in "psychosomatic dermatology" has been announced in the University of Cincinnati College of Medicine by Dr. Stanley E. Dorst, dean, who said the fellowship has been set up to develop further the University's program of teaching future dermatologists the psychologic problems involved in treating skin diseases.

UC's postgraduate teaching program in this field is now two years old and was developed and is being directed by Dr. Leon Goldman and Dr. Maurice Levine, professors and directors respectively of the dermatology and psychiatry departments at the university.

The university's teaching of psychosomatic dermatology has been made an integral part of the overall training of dermatology resident physicians, Dr. Dorst said.

Ohio State Heart Association Elects Officers

Dr. Maurice A. Schnitker, Toledo, was elected president of the Ohio State Heart Association at its annual meeting in Cleveland, April 9. He succeeds Dr. R. W. Kissane, Columbus.

H. Willis Nichols, Jr., Cincinnati industrialist, was elected chairman of the Board, succeeding Irving B. Hexter, Cleveland.

Other officers and executive committee members elected were: Mrs. O. W. Haulman, Youngstown, secretary; Charles W. McCoy, Columbus, treasurer; Dr. John W. Martin, Cleveland; Mrs. Max Petty, Hamilton; Dr. Dale Osborn, Cincinnati; Irving B. Hexter, Cleveland; and R. W. Kissane, M. D., Columbus, members of the executive committee.





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January and his associates¹ have written on the use of tetracycline (ACHROMYCIN) to treat 118 patients having various infections, most of them respiratory, including acute pharyngitis and tonsillitis, otitis media, sinusitis, acute and chronic bronchitis, asthmatic bronchitis, bronchiectasis, bronchial pneumonia, and lobar pneumonia. Response was judged good or satisfactory in more than 84% of the total cases.

Each month there are more and more reports like this in the literature, documenting the great worth and versatility of ACHROMYCIN. This antibiotic is unsurpassed in range of effectiveness. It provides rapid penetration, prompt control. Side effects, if any, are usually negligible.

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 For more rapid and complete absorption. Offered only by Lederle!

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¹January, H. L. et al: Clinical experience with tetracycline. *Antibiotics Annual* 1954-55, p. 625.



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Ohio Medical Indemnity . . .

Better Coverage for Large Medical Bills Announced; Package Contract Includes In-Hospital Medical, Anesthesia Coverage; Officers Elected

 HIO MEDICAL INDEMNITY, the pre-paid medical plan sponsored by the Ohio State Medical Association, recently announced increased benefits for all of its two million members. The following increases became effective on April 1, 1956.

1. Multiple surgical and fracture procedures performed at the same time resulting from an accident: Full indemnity will be provided for the first procedure, full indemnity for the second procedure, and one-half the indemnity for the third procedure, subject to a maximum of \$200 on the Standard Contract—\$300 on the Preferred Contract. Prior to April first, accident cases were paid the full indemnity for the first procedure and one-half indemnity for the second procedure. The increase will give the subscriber full indemnity for one additional fracture or procedure.

2. Excision of thyroglossal cyst or sinus: Indemnity payment increased from \$75 to \$125 on the Standard contract and from \$100 to \$200 on the Preferred contract.

3. Complete transfusion of Rh babies: These transfusions will now be considered as an eligible claim under the surgical portion of the contract.

4. Limitation for surgery for the same or related conditions in the same three-month period: The \$200 limit on the Standard contract and the \$300 limit on the Preferred contract are now removed. Full indemnities for operations for related conditions will now be paid when performed at different times.

In discussing these increased benefits, Dr. Carll S. Mundy, President of Ohio Medical Indemnity, pointed out that Ohio Medical is aiming for better coverage for the large medical bills. He stated that the increase in payments on accident cases was needed because of the serious and multiple injuries in today's automobile accidents. Dr. Mundy further pointed out that the removal of the limitation for related operations in the same three-month period will permit Ohio Medical to provide better payments for those serious cases requiring multiple stage surgery.

A special committee of the Board of Directors, with Dr. E. K. Yantes as chairman, has been studying further improvements in Ohio Medical's contracts. The committee recommended that Ohio Medical Indemnity expand its coverage to bring more of the subscribers under the in-hospital medical program (for non-surgical illnesses), as well as anesthesia coverage. This

program recommended by the committee and adopted by the Board of Directors is as follows:

"PACKAGE" CONTRACT

On April 1, 1956, Ohio Medical began offering only a package contract of surgical, in-hospital medical and anesthesia coverages to newly enrolled groups. The group may elect either the Standard package or the Preferred package.

The Standard package includes surgical benefits up to \$200 per schedule of indemnities—in-hospital medical coverage for 70 days per year at the rate of \$5 for each of the first two days of each hospital admission and \$3 per day for the next 68 days for medical treatment in a hospital for non-surgical cases—a maximum of \$25 for professional administration of anesthesia per schedule of anesthesia indemnities.

The Preferred package provides surgical benefits up to \$300 per schedule of indemnities—in-hospital medical coverage for 120 days per year at the rate of \$10 for the first day, \$5 per day for the next three days, and \$4 per day for the next 116 days—anesthesia payments up to \$40 per schedule of anesthesia indemnities.

Both the Standard and Preferred contracts also include radiation therapy benefits for treatment of neoplastic diseases either in the hospital or physician's office.

SELLING JOB IN PROCESS

All presently enrolled groups are now being notified of the availability of these packages and will be encouraged to add the additional coverages to their present contracts. All "billed at home" Blue Shield members are also being notified of the new coverage.

Mr. Charles H. Coghlan, executive vice-president of Ohio Medical Indemnity, stated that it would take some time to cover the many thousands of groups now enrolled in Blue Shield and that the job would be done in cooperation with the seven Blue Cross Plans working jointly with Ohio Medical Indemnity. Mr. Coghlan further stated that while in-hospital medical coverage and anesthesia coverage had been available in the past by adding riders to the surgical contract, it had always caused a great deal of confusion to patients, physicians and groups. "By putting the three coverages into a package, we will reduce administrative costs, and this saving coupled with the experience gained on these coverages in the Standard contract will permit a

reduction in the rates now charged for these coverages."

The new rates for the Standard package will be 80 cents per month for the single contract and \$2.45 per month for the family contract. Previously the rates were 83 cents per month for the single contract and \$2.55 per month for the family contract. Because of the limited experience with the Preferred contract, the rates for the Preferred package will remain at \$1.25 per month for the single contract and \$3.75 per month for the family contract.

OFFICERS RE-ELECTED

At the Annual Meeting on April 18 the following officers of Ohio Medical Indemnity were re-elected: Dr. Carll S. Mundy, Toledo, president; Dr. C. C. Sherburne, Columbus, vice-president; Mr. Charles H. Coghlan, executive vice-president; Mr. Charles S. Nelson, secretary-treasurer; Mr. Frank W. Van Holte, assistant treasurer. Mr. Wayne E. Stichter, Toledo, was re-appointed general counsel.

DIRECTORS

The following members of the Board of Directors were re-elected: Robert T. Allison, Jr., M.D., Akron; C. H. Campbell, Columbus; H. M. Clodfelter, M.D., Columbus; R. Dean Dooley, M.D., Dayton; D. A. Endres, Youngstown; D. W. English, M.D., Lima; James B. Fenner, Toledo; Clair E. Fultz, Columbus; Charles N. Hoyt, M.D., Chillicothe; Edgar W. Jones, Canton; James S. Mathews, M.D., Cincinnati; Charles Mills, Marysville; Carll S. Mundy, M.D., Toledo; George H. Sackett, M.D., Cleveland; L. Howard Schriver, M.D., Cincinnati; C. C. Sherburne, M.D., Columbus; Harold W. Slabaugh, Akron; Robert G. Smith, M.D., Circleville; David L. Temple, Dayton; Edmond K. Yantes, M.D., Wilmington; and Starling C. Yinger, M.D., Springfield.

Since Ohio Medical Indemnity, Inc., was founded in 1945 over \$57,000,000 has been paid out in benefits to its subscribers, who now total some 2,070,000 Ohioans. This spectacular growth in membership places Ohio Medical Indemnity, Inc., in the position of the fourth largest "Blue Shield" plan in the country.

GROWTH OF OMI

Here are some interesting data taken from the annual report of Ohio Medical Indemnity as of December 31, 1955:

At the close of 1955 OMI completed its tenth year of continual growth.

Claims incurred for the year equalled \$11,824,336, an increase of over \$1,900,000 over the previous year. (Monthly claim payments are now exceeding a million dollars a month.)

The number of claims paid in 1955 was 224,562, an increase of more than 32,000 over 1954. Monthly average in December reached 21,500.

At the end of the year there were 2,050,489 persons covered by OMI. Of this number, 1,757,004 were covered by Standard Contracts, and 293,485 by Preferred Contracts.

Many of the Standard and Preferred Contract holders also carry In-Hospital Medical coverage. Persons under this coverage included 651,957, an increase of 338,627 for the year.

Members covered by the Standard Anesthesia Rider as of the end of the year numbered 29,529 an increase of 19,778 for the year.

Percentage of Blue Cross members enrolled in Ohio Medical was 68 per cent, an increase of 4.3 per cent.

Nationwide there were 35,749,734 persons enrolled in 75 Blue Shield plans as of the end of the year.

Chest Physicians To Meet in Germany

On invitation of the German Federal Government the Fourth International Congress of the American College of Chest Physicians will be celebrated in Cologne, Germany, from August 19 to August 23, 1956. The German Federal Government, the state of North-Rhine-Westphalia and the City of Cologne will be the hosts as far as all arrangements for the Congress are concerned.

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HAVE PROLONGED
THE WORKING PERIOD
AND LIFE SPAN OF
COUNTLESS SUFFERERS
FROM CONGESTIVE
HEART FAILURE..."*

TABLET

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*Fishberg, A. M.: Hypertension and Nephritis, ed. 5, Philadelphia, Lea & Febiger, 1954, pp. 177-178.

00756

Ohio Mental Hospitals . . .

Dr. Porterfield Announces Continuing Decrease in Number of Patients Due Primarily to Increase in Personnel and Use of Tranquilizing Drugs

THE number of patients in Ohio's hospitals for the mentally ill continues to drop, it was announced by Dr. John D. Porterfield, director of the Department of Mental Hygiene and Correction.

The figure late in March stood at 26,981, which is 340 below the all-time high reached July 1, 1955. It is also 225 below the figure of 27,206 recorded at the same time a year ago.

Dr. Porterfield pointed out that the drop in the number of institutionalized mentally ill has been accomplished despite a record high admission rate to Ohio's mental institutions of more than 10,000 a year.

On the other hand, Dr. Porterfield said, the number of mentally retarded in Ohio institutions is still climbing. At this time a year ago there were 7,301 institutionalized mentally deficient; now there are 7,508.

The number of institutionalized epileptics has fallen during the past year from 1,563 to 1,425.

"Despite the rise in the number of mentally retarded," Dr. Porterfield said, "there has been an overall drop of 156 in the total number of patients in Ohio's mental institutions—from 36,070 a year ago to 35,914 at present.

PERSONNEL INCREASE

"Much of the decline in the number of mentally ill—and it is the mentally ill that represents by far the greatest portion of our total caseload—can be attributed to the substantial increase during the past year in the number of treatment personnel in Ohio's mental hygiene program. With more doctors, nurses, therapists, psychologists and attendants, we are able to have an increasingly better treatment program. As the number of treatment personnel continues to grow, there should be a corresponding increase in the number of patients we are able to discharge as cured.

USE OF DRUGS

"The second important factor in the continued decline in the number of Ohio's mental patients is the use of the tranquilizing drugs. The success of these drugs—chlorpromazine and reserpine—in rendering patients much more amenable to treatment has been most encouraging.

"The third factor is that phase of the program's social service functions concerned with seeing that discharged patients make a successful transition back to the community. During the past year there has been a 50 per cent increase in the program's social service personnel.

"This factor will assume even greater proportions in the months ahead through the recently announced stepped up program to get non-psychotic elderly patients out of our hospitals and into a proper community setting. Approximately 9,000 of Ohio's mental hospital patients are over 65 and a great proportion of these could leave the hospitals under properly supervised conditions."

OUTLOOK FOR RETARDED

Dr. Porterfield also said that "despite the increase in the number of institutionalized mentally retarded, there is now more hope than ever before that this trend can be checked in the not too distant future.

"For the first time in history the Columbus State School has adequate facilities with which to train those mentally retarded who are trainable, in preparation for their return to the community. Roger M. Gove Hall, opened this past winter on the state school campus, offers both academic and vocational programs in a bright, modern, completely equipped school structure.

"Additional training facilities for the state's mentally retarded are planned under the long range building program."

Ohio Physician Golfers To Meet in Dayton, Thursday, June 21

The 31st annual tournament of the Ohio State Medical Golfers' Association will be held on the Miami Valley Golf Club course in Dayton on Thursday, June 21. This is one of the well-known courses of the State and promises both a challenge and a pleasure to those who participate.

All Ohio physicians who are interested in golf are invited to attend. A nominal fee is customary.

Tee off time is 8:30 a.m. to 2:00 p.m. A buffet luncheon will be served at the club from 11:00 a.m. to 2:00 p.m. The customary banquet will be held at 7:00 p.m.

Co-chairmen of the Dayton committee on arrangements are Dr. A. J. Carlson and Dr. John S. Stahler.

Officers of the organization for this year are: Dr. Donald W. English, Lima, president; Dr. D. A. Russell, Lorain, president-elect; Dr. Paul A. Stoodt, Mansfield, vice-president. Secretary is Mr. Robert Elwell, 3101 Collingwood Blvd., Toledo 10, who will furnish additional information to those who are interested, and accept reservations.

Notes on the Diagnosis and Management of "Dizziness"

III. Ménière's Syndrome



1. Paroxysmal Whirling Vertigo. *This consists of sudden attacks of dizziness, often when the patient is at rest or asleep. The patient may feel that he himself is whirling or that fixed objects about him are whirling. The attack usually lasts for a few minutes; occasionally it is severe for weeks or subacute for months.*



2. Subtotal Hearing Loss.

Deafness will usually affect the high tones and it may be unilateral or bilateral. Sometimes the hearing loss is severe and also progressive.

3. Tinnitus. *This is usually unilateral and present in the ear with greater hearing loss and is without a definite pattern.*



Fewer diagnostic errors¹ will result if a "triad of symptoms" is required of patients with suspected Ménière's syndrome. These are the symptoms of typical Ménière's syndrome:

1. Severe paroxysmal vertigo which may be of two types; either the patient feels that he is whirling or that objects about him are whirling.
2. Fluctuating subtotal hearing loss, usually affecting the higher tones, is noted at the same time as vertigo.
3. Tinnitus, usually unilateral, is associated with the deafness and dizziness.

With Ménière's syndrome there is no definite localization² by the Bárány (vestibular reaction) test and results of the caloric test are not diagnostic. Physical examination should rule out disease of the central nervous or cardiovascular systems before a diagnosis is made.

"Treatment with Dramamine® . . . is effective³ in aborting and preventing attacks of Ménière's syn-

drome . . . will prevent or arrest attacks of vertigo. It will also reduce the intensity of the tinnitus and so may save some of the hearing in the affected ear."

Dramamine is recommended for Ménière's syndrome as the sole therapy or in combination with other treatment programs.

It is a therapeutic standard also for motion sickness and is useful for relief of nausea and vomiting of radiation sickness and fenestration procedures.

Dramamine (brand of dimenhydrinate) is supplied in tablets (50 mg.); Supposicones® (100 mg.); ampuls (250 mg.); liquid (12.5 mg. in each 4 cc.). G. D. Searle & Co., Research in the Service of Medicine.

1. DeWeese, D. D.: Symposium: Medical Management of Dizziness. The Importance of Accurate Diagnosis, Tr. Am. Acad. Ophth. 58:694 (Sept.-Oct.) 1954.
2. Jackson, C., and Jackson, C. L. (editors): Diseases of the Nose, Throat, and Ear, Philadelphia, W. B. Saunders Company, 1945, pp. 368; 414.
3. Queries and Minor Notes: Ménière's Syndrome, J.A.M.A., 141:500 (Oct. 15) 1949.

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Central Cancer Registry Opened . . .

Handles Details of Voluntary Reporting Project Now Functioning Under Direction of Committee Selected by OSMA and Other Groups

AFTER almost two years of study and planning, the Ohio Central Cancer Registry began functioning on January 1, 1956.

This voluntary agency is housed in quarters provided by the Ohio Department of Health in the State Office Building, Columbus. Abstracts of the records of cancer cases from several local registries have been received and initial files have been started.

Only a few local registries are participating at present. It is anticipated that the number of participating registries will increase appreciably by the end of the year as a result of an educational program which will be carried on in many of the counties.

ACTION STARTED APRIL 12, 1954

Opening of the central cancer registry is the tangible result of action taken on April 12, 1954. On that day the Committee on Cancer of the Ohio State Medical Association met to consider the question of establishing voluntary cancer registries in Ohio. The deliberations resulted in the formulation of two recommendations. These were:

(1) That a uniform system of voluntary cancer registries be established in Ohio; (2) that the Ohio Department of Health, the Ohio Division of the American Cancer Society and its local units, the Ohio Hospital Association, and the Ohio State Dental Society be officially requested by the Ohio State Medical Association to work with the Association, through the Committee on Cancer, in developing details and policies for such a program.

On May 23, 1954, The Council of the Ohio State Medical Association approved the foregoing recommendations.

OTHER GROUPS PARTICIPATE

On February 20, 1955, representatives of the Ohio State Dental Society, Ohio Hospital Association, Ohio Chapter, American Cancer Society, and Ohio Department of Health met with the Cancer Committee of the Ohio State Medical Association to discuss ways and means of establishing and operating the central registry.

The following recommendations were drafted and later approved by the governing board of each of the organizations:

The central registry should be housed and serviced by the Ohio Department of Health because it has facilities and personnel which can be utilized for this project.

All counties should be encouraged to establish cancer registry facilities within the county in order to make the state-wide program more effective.

PURPOSES ENUMERATED

In its operations, the Central Cancer Registry would serve the following purposes: (1) Maintain a record system which would include a continuous case history in abstract form of all cancer cases reported; (2) maintain a mechanism for obtaining current status information on cases; (3) provide basic data for research and special studies; (4) serve as a source of valuable material for educational and control activities throughout the state and in local communities; (5) aid local communities in assembling data which would point up specific needs for local diagnosis and treatment facilities and services.

SPECIAL COMMITTEE TO GOVERN

An inter-organization committee of nine, to be known as a Cancer Coordinating Committee, should be established to serve in an advisory capacity to the Central Cancer Registry.

Under the guidance of the coordinating committee, the Central Registry should develop a standard form for reports from local registries, hospitals, physicians, dentists, laboratories, and other sources.

Each local registry should set up and maintain a record system of its own choice. However, each local registry should be requested to include in its records all information needed by the Central Registry as specified in the standard report form. Also, each local registry should be requested to make reports to the central office at fixed intervals, to be determined by the coordinating committee.

Each local registry should develop, and be responsible for, a follow-up system of its cases and be prepared to report the current status of cases to the Central Registry, periodically, on request.

UNIFORMITY SOUGHT

All local registries should be asked to use the same cancer code system to facilitate reporting to the Central Registry. A suggested standard code system should be developed by the Central Registry under the guidance of the coordinating committee.

Hospitals with cancer clinics and registries which are currently approved by the American College of Surgeons should form the nucleus for the initial operation of this program. Other hos-

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pitals and newly-formed registries should be included at the discretion of and recommendations by the coordinating committee.

Several established local registries should be asked to cooperate in a trial run.

PERSONNEL OF GOVERNING BODY

Since the meeting on February 20, 1955, a Coordinating Committee has been named and it has met on several occasions. The committee consists of five members of the Cancer Committee of the Ohio State Medical Association, namely: Dr. Arthur G. James, Columbus, (chairman of both committees), Dr. C. E. Hufford, Toledo, Dr. Carl A. Wilzbach, Cincinnati, Dr. W. D. Nusbaum, Lancaster, and Dr. A. E. Rappoport, Youngstown. Other members of the committee are: Dr. Hamilton B. G. Robinson, Ohio State Dental Society; Mr. Edgar O. Mansfield, Columbus, Ohio Hospital Association; Mr. L. E. Herget, Cleveland, Ohio Chapter, American Cancer Society; Dr. Ralph E. Dwork, Columbus, director, Ohio Department of Health; and Dr. George F. Badger, Cleveland, ex-officio, professor of biostatistics, Western Reserve University.

Mr. William Veigel will serve as executive secretary of the Central Registry. He is chief of the State Division of Vital Statistics. Assisting him will be Mrs. Nancy Lucas, a staff employee of the Ohio Department of Health, who has been working for almost two years with the Cancer Committee of the OSMA on this project.

Under the direction of the Coordinating Committee the Ohio Department of Health has made available statisticians, nosologists, records and procedures consultants, mechanical tabulating equipment and information on cancer deaths from official death certificates.

FORMS AND CODE ADOPTED

At the request of the Coordinating Committee, personnel of the Ohio Department of Health prepared the basic record forms for use in registry operation. These were approved by the Coordinating Committee and distributed to selected local registries.

The Coordinating Committee, after considerable investigation and discussion, determined that the International Statistical Classification of Diseases, Injuries, and Causes of Death should be the code used for the classification of cancer cases.

A trial run on central registry operation was conducted jointly by members of the Ohio Department of Health staff assigned to the central registry and the staff of several local registries. The purposes of the trial runs were to test the record forms; to determine problems in abstracting cases and follow-up information; to investigate the problems of established local registries relative to supplies, equipment, and personnel needed for participation in the central registry

operation; to explore effective working relationships between central and local registries.

For the time being the Central Registry will confine its activities to getting its office procedures established; to processing reports being received from the few local registries now participating; and assisting certain local areas, which have requested help, in establishing a local registry. As time goes on, field work will be done in an effort to stimulate the organization of registries in counties where no steps have been taken to organize one.

All of these activities will be carried on under policies and recommendations set by the Coordinating Committee and the parent organizations and in cooperation with local medical, hospital, dental and cancer societies, and local public health departments.

Obviously, since this entire program is voluntary in character, the cooperation of all individuals and organizations directly involved in both professional and non-professional cancer activities in all counties will be necessary to insure the success of the project.

New AMA Directory Soon Will Be Ready for Distribution

After 20 months of work, the 19th edition of the American Medical Directory has been completed, and the first copies will be shipped to subscribers during the last week of May, Dr. George F. Lull, secretary and general manager of the AMA, announced.

The edition, the first since 1950, was originally scheduled for publication in 1952, but had to be postponed because the changeover during that period to a dues-paying membership structure in the AMA made it impossible to obtain an accurate list of members of the Association. Work began on the new edition late in 1954, with the sending of information cards to physicians, and Editor Philip E. Mohr of the AMA Directory Department, says that "it was only with the cooperation of the medical profession and allied organizations that it was possible to bring the Directory up to date and produce a book of this scope."

The price of the Directory is \$30 a copy, including postage within the United States. Orders can be placed by writing to Philip E. Mohr, Editor of the Directory, American Medical Association, 535 N. Dearborn St., Chicago 10.

The new edition contains 3,122 pages, and lists information on 240,638 physicians in the United States, its dependencies, and Canada. It also lists American graduates temporarily located in foreign countries. Since the 1950 Directory, more than 250,000 changes of address have been recorded in the files of the Directory-Biographical Department, 46,348 names have been added, and 24,225 have been deleted because of death, with an additional 1,172 deleted for other reasons.

How to design a sound investment program

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Because we are specialists in helping doctors with their investment planning, we can offer you many worthwhile suggestions about how best to set up a sound investment program. We can help remove much of the confusion and misunderstanding that too often cloud the subject of investments, and show you how to select the program that best fits your needs.

We appreciate the wonderful reception the doctors accorded us at the Ohio State Medical Association meeting in Cincinnati last April and again in Cleveland this April. If you missed our exhibit at these meetings, we invite you to stop and see us at the Ohio Academy of General Practice meeting in Columbus this September and discuss your investment problems with us.

If you would like more information about planning an investment program, fill out the attached coupon and send it to us today. There's no obligation, of course.

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Hospital Accreditation . . .

Joint Commission Issues New Edition of Standards for Hospital Accreditation, Making Several Changes in Its Crediting Methods

THE Board of Commissioners of the Joint Commission on Accreditation of Hospitals has approved a new edition of the "Standards for Hospital Accreditation." The major change has been an attempt to separate basic principles and methods of procedure. In the process, the Standards have been amended slightly. Those changes which should be of interest to medical staffs, governing boards, and administrators are as follows:

1. The requirement that all patients on admission have a serological test for syphilis has been dropped. This is now optional with the hospital. Hospitals should determine the legal requirements in their respective states concerning the serological test for syphilis, especially those regarding obstetrical patients.

2. Recorded pelvic measurements on obstetrical patients are no longer required for accreditation. This decision was reached on the basis of investigation and consultation with the American Academy of Obstetrics and Gynecology. It is acknowledged that this is somewhat of a controversial issue and the decision whether or not to take pelvic measurements is left to the individual hospital staff.

3. A recording thermometer on the discharge line of every autoclave is no longer required. Greater emphasis will be placed on methods of packaging supplies and packing autoclaves to insure proper sterilization. The requirement that cultures be done at least monthly is still in effect.

4. An automatic stop order on dangerous drugs has been added. Experience has shown that this is good practice and, with the increased use of drug therapy, is becoming more important as a protection to patients. The medical staff of the individual hospital should determine the time limit and the drugs to be included. Many hospitals have a 48-hour limit and include narcotics, hypnotics, antibiotics and anticoagulants.

5. A written plan for the reception and care of mass casualties is an added requirement. This plan should be well known to key medical and administrative personnel and, if possible, rehearsed several times a year.

This requirement was added because it is common knowledge that hospitals which have been faced with the sudden need to care for large numbers of patients as the result of a bus accident, explosion, fire, or flood have been unprepared. Cognizant of this, medical and hospital groups have been studying the problem and, as a result, the American Hospital Association has published two handbooks, *Principles of Dis-*

aster Planning, and *Readings in Disaster Planning for Hospitals*.

The *Principles* is a step-by-step explanation of how to prepare the hospital to meet possible disaster with equipment and informed personnel. The *Readings* is a compilation of reports of how individual hospitals have handled community crises. If a hospital wishes help in developing plans, these guides may be of assistance. They can be procured from the American Hospital Association. The Commission does not have copies for distribution.

ELIMINATE POINT SCORES

Also, the Commission has revised the survey report forms, commonly referred to previously as the "scoring report." The survey report is in two parts. One part is sent to the hospital to be completed and held for the field representative. The other is completed by the surveyor. In combination they constitute the report of the survey. Considerable information which was included in the old scoring report now appears on the form which the hospital prepares.

A major change in the new forms is the elimination of the "point scores." This was done by the Board of Commissioners because it has become increasingly apparent that the use of a quantitative numerical score to measure quality patient care often distorted proportionate values. On the revised forms, the surveyor will indicate for each department or service whether in his opinion it should be fully accredited, provisionally accredited, or not accredited. The aggregate of these, with each department significantly considered, will determine the over-all outcome.

The pharmacy or drug room has been included in the "Essential Divisions." In the former report it was in the "Complementary Divisions." The Board of Commissioners consider it essential that a hospital maintain a pharmacy or drug room which is satisfactorily controlled and supervised. Information is also included on the new forms about the dental department and the emergency service which are included in the "Complementary Divisions."

There still remained at the end of 1955, 322 hospitals accredited under the American College of Surgeons program which have not yet been surveyed by the Commission. There also remained 128 provisionally accredited hospitals and 210 new requests which the Commission was unable to schedule for survey. At the end of the year, there were 3,102 hospitals fully accredited and 528 provisionally approved—a total of 3,630.

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Debunks Hoxsey Treatment for Cancer...

U. S. Commissioner of Food and Drugs Issues Official Statement to The Public; Declares Treatment a Gross Deception to the Consumer

A WARNING against the so-called Hoxsey cancer treatment was released to all newspapers of the nation on April 4 by George P. Larrick, U. S. Commissioner of Food and Drugs, U. S. Department of Health, Education, and Welfare.

Following is Mr. Larrick's statement:

"Sufferers from cancer, their families, physicians, and all concerned with the care of cancer patients are hereby advised and warned that the so-called Hoxsey treatment for internal cancer has been found by the United States Court of Appeals for the Fifth Circuit, on the basis of evidence presented by the Food and Drug Administration, to be a worthless treatment.

"The Federal Food, Drug, and Cosmetic Act authorizes dissemination of information regarding drugs in situations involving imminent danger to health or gross deception of the consumer.

"The Hoxsey treatment for internal cancer involves such drugs. Its sale represents a gross deception to the consumer. It is imminently dangerous to rely upon it in neglect of competent and rational treatment.

"The Hoxsey treatment costs the patient \$400 plus \$60 additional fees; expenditures which will yield nothing of any value in the care of cancer. It begins with a superficial inadequate examination at the Hoxsey Cancer Clinic, Dallas, Texas, or Portage, Pennsylvania. The patient at Dallas is then supplied with one of the following "cancer" medicines: Black pills, red pills, a brownish-black liquid, or a light red liquid. The black pills and the brownish-black liquid contain: Potassium iodide, licorice, red clover blossoms, burdock root, Stillingia root, berberis root, poke root, cascara sagrada, prickly ash bark, and buckthorn powder. The red pills contain potassium iodide, red clover, Stillingia root, poke root, buckthorn, and pepsin. At Portage the patient is given the same "cancer" medication although the colors of the pills are different. The light red liquid medicine is potassium iodide in elixir of lactated pepsin. There is evidence that potassium iodide accelerates growth of some cancers.

"The Food and Drug Administration has conducted a thorough and long-continuing investigation of Hoxsey's treatment. His claimed cures have been extensively studied and the Food and Drug Administration has not found a single verified cure of internal cancer effected by the Hoxsey treatment. In addition, the National Cancer Institute of the United States Public Health Service has reviewed case histories submitted by Hoxsey and advised him that the cases provided no scientific evidence that the

Hoxsey treatment has any value in the treatment of internal cancer.

"On October 26, 1953, Harry M. Hoxsey, the Clinic, and all persons in active concert with him were enjoined by the United States District Court at Dallas, Texas, from shipping their worthless cancer medicines in interstate commerce with labeling representing, suggesting, or implying that the products are effective in the treatment of any type of internal cancer. While the Government intends to prosecute violations of the injunction, this warning is necessary for the immediate protection of cancer victims who may be planning to take the Hoxsey treatment.

"Those afflicted with cancer are warned not to be misled by the false promise that the Hoxsey cancer treatment will cure or alleviate their condition. Cancer can be cured only through surgery or radiation. Death from cancer is inevitable when cancer patients fail to obtain proper medical treatment because of the lure of a painless cure 'without the use of surgery, x-ray, or radium' as claimed by Hoxsey."

Following on the heels of the U. S. Food and Drug Administration announcement was an article in the April 16 issue of *Life Magazine* regarding Hoxsey. Featured in the article was the following statement by Dr. Charles S. Cameron, medical and scientific director of the American Cancer Society, issued on behalf of the society, pointing out that Hoxsey's claims "have been found wanting":

"There is a perfectly simple and effective way by which claims for new treatments of disease are examined, and this 'due process' of science has served mankind well throughout history. It consists of submitting evidence in an orderly fashion, according to accepted forms, to one's medical or scientific colleagues. Thousands of medical meetings are held in the United States every year, and 200 reputable journals are published regularly—all for one purpose—to provide a forum for those with something worth saying to say it. These forums are of course available to Mr. Hoxsey—but the fact is that they have never published anything he has written because either he will not submit his evidence or nothing he has claimed will stand the test of competent analysis.

"Hoxsey has on more than one occasion submitted reports of 'cured' cases to the experts of the National Cancer Institute and each time their verdict has been the same—namely, there is no evidence thus produced which would justify a closer investigation. The truth is, then, that Hoxsey's claims have been examined by competent authority and have been found wanting."

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In Our Opinion:

Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

IT'S VITAL TO GIVE THE PUBLIC THE FACTS

Sometimes the best laid plans—and programs—fail, or are slowed up considerably, because of a lack of proper public education or poor public relations on the part of those in charge.

In our opinion a good example is the short but stormy career of the food service licensing law. It was passed in 1953. Recently it was amended to provide many exemptions. An arbitrary ceiling was placed on the amount which can be charged for the license.

Why was the measure changed after only two years of trial? Because in some communities the public didn't understand the reasons for the law; how it operated; why it took more than peanuts to finance its operations; the great benefits accruing from strict enforcement and compliance. Somebody goofed on public education.

Also, in some communities officials tried to go too fast. They made a big and sudden hike in license fees. This was done before they had given the public the facts and taken the public into their confidence. In other words they failed to use their heads and failed in the job of public relations.

The aggregate of complaints from here and there gave enough legislators what they considered valid reasons for changing the act.

It is quite possible that this could have been prevented had better public education been carried on and better public relations established in more cities and counties.

WHEN SHOULD YOU GO TO A LAWYER?

Once upon a time there was a physician—a good one—who thought he knew as much about law as he did medicine. So he decided he didn't need a lawyer to handle a certain matter for him—a matter involving legal angles. Naturally, he wound up behind the eight ball and took a financial licking.

All of which leads us to observe that the Ohio State Bar Association has a nifty little pamphlet entitled "Your Lawyer—What He Means To You." In it appears a section headed "When Should You Go To A Lawyer?," reading as follows:

"The best time to go to a lawyer is *before* not after you are in legal difficulty. The old saying that 'an ounce of prevention is worth a pound of cure' is just as important in law as it is in medicine. Your lawyer often may help you to save both money and difficulties if you consult

him first when you are asked to sign papers or take other action affecting your legal position.

"There are many times when you should seek a lawyer's advice for your own protection. The following is a list of a few of the common situations in which your lawyer can be of assistance to you:

"Entering into verbal or written contracts with major financial provisions

"Accidents involving injury to persons or damage to property

"Collection of accounts

"Income, sales and other tax problems

"Buying and selling real estate

"Making a will

"Opinions on titles to real estate

"Organizing or dissolving a business

"Settlement of estates."

The purpose of this piece is not to solicit business for lawyers. It is to warn doctors that they should see a lawyer before trouble happens and to suggest things about which a lawyer should be consulted.

MATERIAL ON CAREERS IN THE HEALTH FIELD

If you ever have occasion to want material on "health careers" for a talk before some high school or college group, get in touch with the Columbus Office. It has some good data which it will be glad to lend.

Among the material are two booklets—Health Careers Guidebook and Partners for Health—published recently by the National Health Council and the Equitable Life Assurance Society.

These will meet a long-time need and will prove valuable reference in providing answers to queries on all careers in the health field.

KEEP IT ON A "DOWN TO EARTH" LEVEL

Pointing out that many times misunderstandings between physician and patient arise because the doctor talks in high powered terms which are confusing to Joe Doak, the Cleveland Academy of Medicine Bulletin hands out this sound advice under the heading "Down to Earth":

"Let us remember therefore to discuss one's illness in terms that he understands. He may be a college graduate or a Ph.D., but he is not conversant with a terminology which is part of our everyday living. This means that we must be articulate in our speech, must take the time to talk to patients and their families, and must remain aware of the intelligence and education of the people with whom we are conversing."

Do You Know? . . .

Dr. E. A. Baber, superintendent at Longview State Hospital, Cincinnati, since 1923, retired from that post on March 31, at the age of 72. Before going to Longview, he was for 12 years superintendent at the Dayton State Hospital.

* * *

Bethesda Hospital in Zanesville has completed its successful drive for \$1,500,000 for the construction of a new wing and complete modernization of the hospital. Previously rated at 145 beds, the addition will increase the capacity by about 60 beds.

* * *

Dr. Jonathan Forman, Editor of *The Journal*, conducted a workshop on medical writing in connection with the meeting of the American College of Allergists in New York City on April 18. Also he was re-elected to the board of directors of the American Foundation for Allergic Diseases.

* * *

In the new American Medical Directory, due out this month, the number of physicians listed in the United States is 218,061, a gain of 16,784 since the 1950 edition was published, or an average yearly gain of 2,797. Ohio showed a gain of 990 physicians in the same period.

* * *

Dr. C. E. Hufford, Toledo, recently received the distinguished medal and certificate of the American Cancer Society in recognition of his contributions in the control of cancer. He is the fourth Ohioan to receive the award since presentation started about 20 years ago. Dr. Hufford is a member of the OSMA Committee on Cancer, helped organize the Ohio Cancer Society and is president of the Radiological Society of North America. Dr. B. S. Park, Painesville, president of the Ohio Cancer Society, made the presentation.

* * *

Dr. William J. Neal, Archbold, was elected president of the Northern Tri-State Medical Association which met in Ann Arbor, Mich., recently. The organization is composed of physicians of the neighboring areas of Ohio, Indiana and Michigan.

* * *

Dr. Tom F. Lewis, Columbus, was installed as president of the Ohio State Surgical Association at the annual convention in Cleveland. Other officers of the association are Dr. John H. Lazzari, Cleveland, president-elect; Dr. George N. Bates, Toledo, secretary; and Dr. Philip W. Smith, Marion, treasurer.

* * *

Dr. Robert M. Stecher has been elected to his sixth term as board president of the Cleveland Health Museum.

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You and Your Public . . .

Patients Get an Impression of the Doctor from His Office Personnel; Here Are Some Pointers for Receptionists and Other Office Helpers

THE Public and Professional Relations Bureau of the Medical Society of the State of New York has published a booklet entitled "Seven PR Pointers for Medical Personnel."

In introducing the seven points involved, the editors say: "The activities of a doctor's office assistant are so closely associated with his that often patients look upon everything the assistant does as part of the way the doctor practices medicine.

"How to conduct herself to create the impression that all her activities are an extension of the doctor's, is the purpose of these seven PR Pointers":

Put Your Best Foot Forward. Come to the office dressed in simple but attractive clothing. Appear smart but not too ornate. Have your hair under control. Some physicians prefer a white uniform or smock. Keep your hands clean.

Cheerfulness Promotes Friendliness. Everybody likes a cheerful hostess. Patients should feel they are welcome. Greet each patient as they enter. See that they are seated comfortably. Advise them of the status of the doctor's schedule. Answer the telephone promptly and courteously—be as brief as the call permits. A pleasant voice and an interested and sympathetic manner always reassures the patient. Repeat back to calling party any message, including caller's phone number.

Efficiency Promotes Respect. Obtain adequate information from all new patients. Include marital status and medical insurance data. The location of your desk should permit you to greet each patient as they enter and leave, and still allow you to reach the doctor without disturbing anybody.

Keep a daily and accurate record of all services rendered and all monies paid out or received. Send out monthly statements promptly and regularly. These practices facilitate the preparation of monthly and yearly reports for tax and other purposes.

Tactful, Simple Explanations Are Helpful. Most people are not acquainted with medical phraseology; therefore, some have difficulty understanding everything the doctor may tell them about their problems. Doctors' assistants should be prepared to explain tactfully and thoroughly, in simple everyday language, any questions of patients relating to therapy or treatment the doctor orders. Of course, if the assistant has any doubts, she should not hesitate to ask the doctor to explain it in detail to the patient.

Patients Like Attention. Everybody likes to feel that they have the undivided attention of the person to whom they are talking. Pressure of time occasionally makes it difficult for a patient to give the doctor a complete history of the complaint. Whenever you become aware of such a situation you can be of great service to the patient and the doctor by listening to the patient, if time permits. Often a patient will reveal a detail or a psychological reaction, which may be the key to his problem. Of course, personnel serving an office full of waiting patients and engaged in answering a constantly ringing telephone cannot be expected to take time out for a 'chat.'

Planned Schedules Make For Lighter Work. Plan your schedule for the day, week, and month. Efficient scheduling of appointments permits the doctor to give his patients the best medical service. A cardinal principle for assisting the doctor in developing good patient and public relations is to make certain that only an emergency can interfere with his scheduled appointments. As noted, patients like to feel that the time the doctor spends with them is theirs and theirs alone. Interruptions should be kept to a minimum. Office hours belong to the doctor and his patients. Your schedule should be arranged so that these hours are devoted to him and his patients exclusively.

Office personnel can profit by studying the doctor's schedule and planning accordingly. Long case histories can be typed before office hours. Clerical work and bookkeeping can be done at other times. Arrange your time so that you can devote all office hours to the patients, the doctor and the telephone.

Loyalty Inspires Confidence. Loyalty to the doctor and his patients is a key quality of every efficient doctor's assistant. Every patient's complaint or illness is different. The therapy prescribed is a confidence to be shared by the patient and physician alone. Treatment and prescriptions are discussed with the doctor and patient only. Words of praise or criticism concerning the doctor should be repeated only to the doctor.

Communications between doctor and patient are privileged by law. An office assistant hearing or reading anything of a confidential nature about a patient is morally and legally bound to treat it as a confidence. Office assistants who respect such confidences find the practice a firm foundation for lasting friendships.

Procedure for Re-registration Of Nurses Is Outlined

The new Ohio Nursing Practice Act requires registered nurses to renew their certificates annually beginning for 1957 (refer to December 1955 issue of *The Journal*, page 1239). The following procedure for this purpose has been announced by the Ohio State Nurses Association:

The new Ohio Nursing Practice Act requires the Ohio registered nurse to renew her certificate annually and pay an annual renewal fee, not to exceed \$2.00, if she wishes to practice legally in Ohio as a registered nurse during the succeeding year.

The law also requires the Board of Nursing to mail the Ohio registered nurse an application to renew her certificate for 1957 on or before December 1, 1956. The amount of the fee and rules pertaining to annual renewal have not been adopted by the new Board. A public hearing will be held before the rules are adopted.

The procedure which will be followed in 1956 only is for nurses who are not members of the Ohio State Nurses Association to write directly to the State Board of Nursing Education and Nurse Registration, between August 1 and November 1, 1956, and request an application blank.

For this year applications will be mailed to all nurses who are on the current membership list of the Ohio State Nurses Association.

Severely Disabled Veterans Taking More Training

Severely disabled Korea veterans are entering vocational rehabilitation training at a much greater rate than veterans with lesser disabilities, a Veteran Administration study disclosed.

According to the VA study, one out of every five Korea veterans with disabilities rated at 60 per cent or more have enrolled for training thus far.

On the other hand, only one out of 10 with disability ratings of less than 20 per cent have taken training.

The middle group—those 20 to 50 per cent disabled—have entered training at the rate of one out of six.

Ohio Valley Proctologists Hold Meeting in Florida

Members of the Ohio Valley Proctologic Society journeyed to Florida for a meeting and program the week of March 25. The Society includes physicians from Indiana, West Virginia as well as Ohio. Meetings were held in the Hollywood Beach Hotel, Hollywood, Florida.

Dr. A. Gerson Carmel, Cincinnati, chairman of the program committee, reported that registration was good and that the meetings were well attended. The program included outstanding speakers from all parts of the country.

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In Memoriam . . .

John L. Carter, M. D., Dayton; Medical College of Ohio, Cincinnati, 1895; aged 84; died March 12; member of the Ohio State Medical Association. A recipient of the State Association's 50-Year Pin, Dr. Carter had been a practicing physician in Dayton since 1918. Prior to moving to Dayton, he had been in West Carrollton and Celma. Dr. Carter was a 32nd degree Mason and a 50-year member of that organization; also a member of the Methodist Church. His daughter with whom he resided survives.

William Hinton Cleveland, M. D., formerly of Rocky River; Starling Medical College, Columbus, 1889; aged 80; died March 16; member of the Ohio State Medical Association through 1953. Dr. Cleveland retired in 1946 after practicing many years in Columbus. His widow and a granddaughter survive.

Frederick Deutsch, M. D., Euclid; University of Vienna, Austria, 1924; aged 56; died March 24 while vacationing in Florida; member of the Ohio State Medical Association. Born and educated in Europe, Dr. Deutsch obtained his license to practice in Ohio in 1940 and had practiced in the Greater Cleveland area since. His widow survives.

Gilbert David Elliott, M. D., Jeffersonville; Medical College of Ohio, Cincinnati, 1896; aged 87; died March 6. Dr. Elliott had been a practicing physician in Jeffersonville for the past nine years. Prior to moving there he had been in South Solon and Kingston. He was a member of the Knights of Pythias. Survivors include his widow, two daughters and a son.

Lindley M. Greene, M. D., Whittier, Calif.; Miami Medical College, Cincinnati, 1882; aged 102; died March 7. Dr. Greene practiced for a short time in Wilmington before leaving for California many years ago.

James Gunn, M. D., Dayton; Howard University, 1922; aged 65; died March 4, the victim of shots fired by an assailant while he sat in his home; member of the Ohio State Medical Association. Dr. Gunn had been a practicing physician in Dayton for 32 years and was active in community affairs, particularly among Negro organizations of that city. He was a member of the Baptist Church, Omega Psi Phi, the Frontier Club of America and other organizations. Surviving are his widow and two brothers.

Elwood M. Hammond, M. D., Massillon; Loyola University Medical College, 1939; aged 46; died March 21 in Arizona where he had gone for his health; member of the Ohio State Medical Association through 1954. Dr. Hammond practiced for about 10 years in Cincinnati before he returned to Massillon which had formerly been his home. He is survived by his widow, two daughters, his mother and a brother.

John Ross Harger, M. D., Alliance; Rush Medical College, University of Chicago, 1906; aged 79; died March 20. Living in retirement with his son-in-law and daughter, Dr. Harger for many years had been a practicing physician in Chicago and was prominent in medical education in that city. He was a past-president of the Chicago Medical Society and active in numerous other organizations. Besides his daughter, he is survived by a son and a sister.

John W. Hassenflue, M. D., Akron; Cleveland Medical College, 1896; aged 81; died March 24; member of the Ohio State Medical Association through 1953. Dr. Hassenflue served virtually all of his professional career in Akron and was among the first group of physicians to receive the 50-Year Pin and Certificate of the Ohio State Medical Association. He had been in retirement for several years. Dr. Hassenflue was a member of several Masonic bodies. He is survived by three daughters and a sister.

Charles Daniel Heisel, M. D., Cincinnati; Ohio Medical College, Cincinnati, 1904; aged 75; died March 25; member of the Ohio State Medical Association and recipient of the 50-Year Pin and Certificate; Fellow of the American College of Surgeons and of the International College of Surgeons; past-president of the Academy of Medicine of Cincinnati; past-president of the Cincinnati Obstetrical Society. Before his retirement, Dr. Heisel served on the staffs of Deaconess, Jewish and St. Francis Hospitals and worked with other hospitals. He was for years surgeon for the Bodmann Widows' Home. Surviving are a brother and a sister.

Dwight J. King, M. D., Findlay; Eclectic Medical College, Cincinnati, 1912; member of the Ohio State Medical Association. Dr. King had been a practicing physician in Findlay for 41 years. For several years he was a member of the State Medical Board of Ohio and served one term as president of the board. He was a former coroner of Hancock County. Affiliations included membership in the Elks Lodge and the Presbyterian Church. Surviving are his widow, three sons, four brothers and four sisters.

Milton Kukuk, M. D., Toledo; Stritch School of Medicine, Loyola University, 1931; aged 51; died March 25; former member of the Ohio State Medical Association. A native of Toledo, Dr. Kukuk practiced there for many years and was former Lucas County health commissioner. He had recently been physician for the B. & O. Railroad. His parents and a step-sister survive.

William A. McCommon, M. D., East Palestine; Ohio Medical University, Columbus, 1897; aged 87; died March 30; member of the Ohio State Medical Association; recipient of the State Asso-

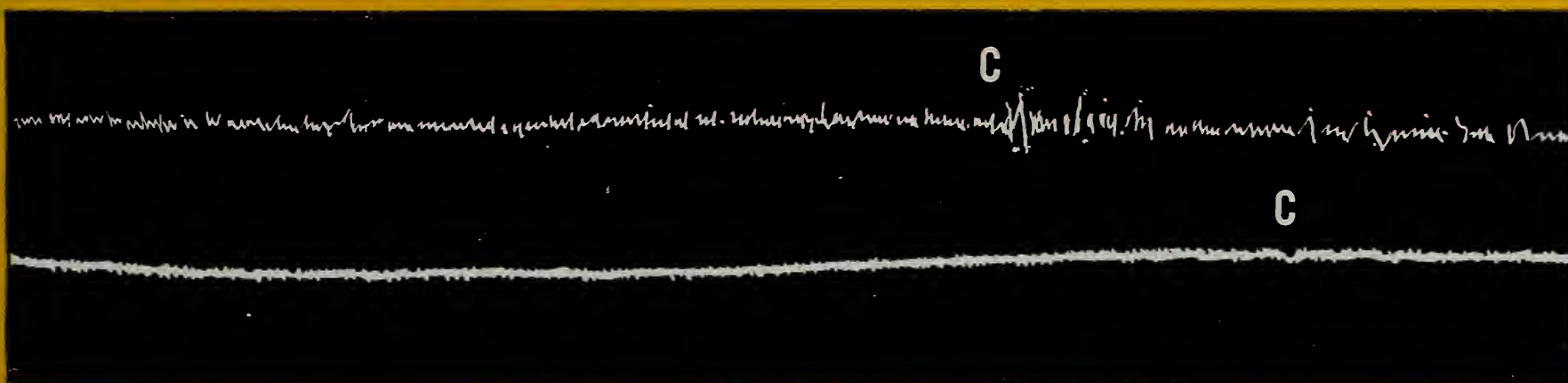
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ambulatory treatment with EQUANIL; showing definite reduction in tension, greater ability to relax, and marked improvement in muscular coordination. C, Point where patient makes effort to relax.¹

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Usual dosage: 1 tablet t.i.d. The dose may be adjusted either up or down, according to the clinical response of the patient.

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1. Dickel, H.A., et al.: West. J. Surg., April, 1956.

anti-anxiety factor
with muscle-relaxing action
... relieves tension



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ciation's 50-Year Pin. Dr. McCommon moved to East Palestine two years after his graduation from medical school and continued in practice there until his retirement 15 years ago. He was a member of the United Presbyterian Church and the Masonic Lodge. Survivors include a daughter, a son and a sister.

David H. Moore, M.D., Urbana; Ohio State University School of Medicine, 1912; aged 72; died March 23 while on a vacation trip to Florida; member of the Ohio State Medical Association. A native of the area, Dr. Moore served most of his professional career in Urbana, and held the post of county coroner for a greater part of the last 40 years. He was a veteran of World War I, having served in the Army Medical Corps. Affiliations included membership in the Masonic Lodge, of which he was a past master, and membership in the Presbyterian Church. Surviving are his widow and a sister.

Francis M. Oxley, M.D., Batavia; University of Cincinnati College of Medicine, 1901; aged 78; died March 28; member of the Ohio State Medical Association and recipient of the 50-Year Pin and Certificate. Dr. Oxley practiced until 1952 in Cincinnati where he was on the faculty of the University of Cincinnati College of Medicine for 21 years. In 1952 he moved to Clermont County as health commissioner, a post he held until the first of this year. A veteran of World War I, he was a member of the American Legion. Also he was a member of the Masonic Lodge. Two daughters survive.

Clayton L. Rice, M.D., New Haven (Hamilton County); Indiana University School of Medicine, 1936; aged 46; died March 17. Formerly with the Veterans Administration, Dr. Rice had been practicing in New Haven since January 1955.

Frederick Rittinger, M.D., Cleveland Heights; University of Toronto, 1920; aged 58; died March 22; member of the Ohio State Medical Association; diplomate of the American Board of Pediatrics; member of the American Association of Pediatrics. Dr. Rittinger had been a practicing physician in Cleveland for 30 years where he was on the pediatrics staff of St. Luke's Hospital, formerly as head of the Pediatrics Department. Surviving are his widow, two daughters and a brother.

North W. Shetter, M.D., Lakewood; Ohio State University College of Medicine, 1917; aged 78; died March 8; member of the Ohio State Medical Association through 1952; diplomate of the American Board of Radiology; member of the Radiological Society of North America and the Cleveland Radiological Society. After completion of residency training, Dr. Shetter moved to Cleveland, set up private practice and founded the X-Ray Department at Lakewood Hospital which he headed for many years. Affiliations included memberships in the Cleveland Yacht Club, the

Kiwanis Club and the Elks Club. Survivors include two sons, a brother and a sister.

George C. Warnock, M.D., Youngstown; Jefferson Medical College of Philadelphia, 1911; aged 72; died March 4; member of the Ohio State Medical Association. Dr. Warnock had been a practicing physician in Youngstown for 44 years and for most of that time was examiner for the Metropolitan Life Insurance Company. He was a member of several Masonic bodies including the Commandery and Shrine and was a member of the Presbyterian Church. Among survivors are his widow, a daughter and a son, Dr. Robert G. Warnock, now with the Armed Forces; also a sister and a brother.

Homer S. West, M.D., St. Clairsville; New York Medical College, 1897; aged 82; died March 17; former member of the Ohio State Medical Association; recipient of the Association's 50-Year Award. Dr. West was a native of St. Clairsville where his father, the late Dr. Henry West practiced. Dr. Homer West returned to St. Clairsville in 1927 from Wheeling where he had practiced for 15 years. In 1942 he was appointed Belmont County health commissioner, a post which he held for eight years. Surviving are his widow, and a sister.

John B. Wilkinson, M.D., Alliance; Cleveland-Pulte Medical College, 1903; aged 75; died March 9; member of the Ohio State Medical Association. Dr. Wilkinson practiced for a short time in Parkersburg, W. Va., and for 10 years in Sebring before moving to Alliance in 1915. In addition to his practice, he was an active lodge worker, being past-president, lieutenant governor and governor of Kiwanis International in Ohio, and a member of the Elks Lodge. Survivors include his widow, two brothers and two sisters.

John D. Wonder, M.D., Dayton; Pulte Medical College, Cincinnati, 1905; aged 75; died March 2; member of the Ohio State Medical Association and recipient of the Association's 50-Year Award; member of the Radiological Society of North America. Dr. Wonder had served all of his professional career in Dayton where he was active in a number of fraternal organizations including a number of Masonic bodies. He was a member of the Methodist Church and the Miami Valley Golf Club. During World War I Dr. Wonder served with the Army Medical Corps. He is survived by his widow.

Pediatric Courses

Dr. Irving J. Wolman, Children's Hospital of Philadelphia, 1740 Bainbridge Street, Philadelphia 46, announced the following short courses at the hospital: Pediatric Advances for Pediatricians and General Practitioners, May 28-June 1; Practical Pediatric Hematology, June 4-6; Blood Group Incompatibilities and Erythroblastosis Fetalis, June 7-8.

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Activities of County Societies . . .

First District

(COUNCILOR: CHARLES T. ATKINSON, M. D.,
MIDDLETOWN)

CLERMONT

Meeting of the Clermont County Medical Society was held on March 21 at the DX Ranch with Dr. Walter H. Culley as host. Guest speaker was Dr. Edgar S. Lotspeich, Jr., of Cincinnati, who discussed "Premature Closing of Cranial Suture Lines."—John T. Crone, M. D., secretary-treasurer.

CLINTON

Members of the Clinton County Medical Society saw a movie, "Toxemia of Pregnancy," following luncheon at the General Denver Hotel in Wilmington, March 6. The film was made in the University of Cincinnati College of Medicine and was obtained by Dr. David Hamilton, program chairman.

Dr. Robert Conard, Clinton County health commissioner, discussed the incidence and reporting of infectious diseases.

HAMILTON

A symposium on Nodular Goiter was held at the March 20 meeting of the Academy of Medicine of Cincinnati. Guest speakers were Dr. George Crile, Jr., Department of Surgery, Cleveland Clinic, Cleveland, and Dr. J. Lerman, clinical associate in medicine, Harvard Medical School, Boston. Local discussant was Dr. Virginia M. Esselborn, assistant professor of medicine, University of Cincinnati College of Medicine.

The Academy had as guest speaker on April 3 Dr. Helen Brooke Taussig, associate professor of pediatrics, Johns Hopkins University School of Medicine, and physician-in-charge, Cardiac Clinic, Johns Hopkins Hospital. She spoke on "Some Cardiac Disorders Amenable to Surgical Treatment."

Second District

(COUNCILOR: G. A. WOODHOUSE, M. D.,
PLEASANT HILL)

CLARK

Continuing a policy of taking active interest in community affairs, members of the Clark County Medical Society currently are concentrating their efforts on four local projects.

One project is a movement to obtain for the people of Springfield a 340-acre park. Endorsement of this project by the Society, pointing out the community and individual health benefits from such a park, received prominent publicity in the local press and was warmly welcomed by city officials.

Another project which also received prominent press play was announcement of an award for the best entry by a Clark County high school stu-

dent at Science Day held by Wittenberg College April 7.

The third project is support of the Springfield Development Council, an organization devoted to inducing new industry to locate in Springfield. This development group had as its first president a member of the Clark County Society, Dr. Ray M. Turner.

The fourth project is giving active assistance to the Heart Fund. Dr. John Harley is the society's advisor to the Heart Fund.

To give them a preview of what to expect when and if they become physicians, pre-medical students at Wittenberg College were guests of the Clark County Society at the society's April scientific meeting. Pre-medical advisors of the college are warm in their praise of this standing custom of the society.

It also is a standing policy of the society to have as guests at each scientific meeting interns at Springfield City Hospital and at Mercy Hospital.—C. W. Edgar.

(Editor's Note: The following report, submitted for an earlier edition of *The Journal*, was unintentionally omitted.)

Accent on public relations and public information was the keynote as the Clark County Medical Society began another year of activity.

At the January 16 general meeting, Dr. E. E. Ash, chairman of the Public Relations Committee, presented a report on the latest American Medical Association policy concerning public relations. Dr. Ash stated that information would be channeled through committees representing the particular aspect of medicine involved in such information.

He encouraged members to report their attendance of state and national meetings, special courses and other relative matters.

In addition, arrangements have been made to have a monthly feature article appear in local newspapers dealing with medical matters of general interest to the lay public. Individual committees will be assigned the responsibility for a monthly article.

Still another step toward emphasizing the role the physician has in community life was the arrangement whereby each and every member of the society would be photographed individually by *The Springfield Daily News* in order that his picture be in the newspaper's files as well as being an up-to-date photograph.

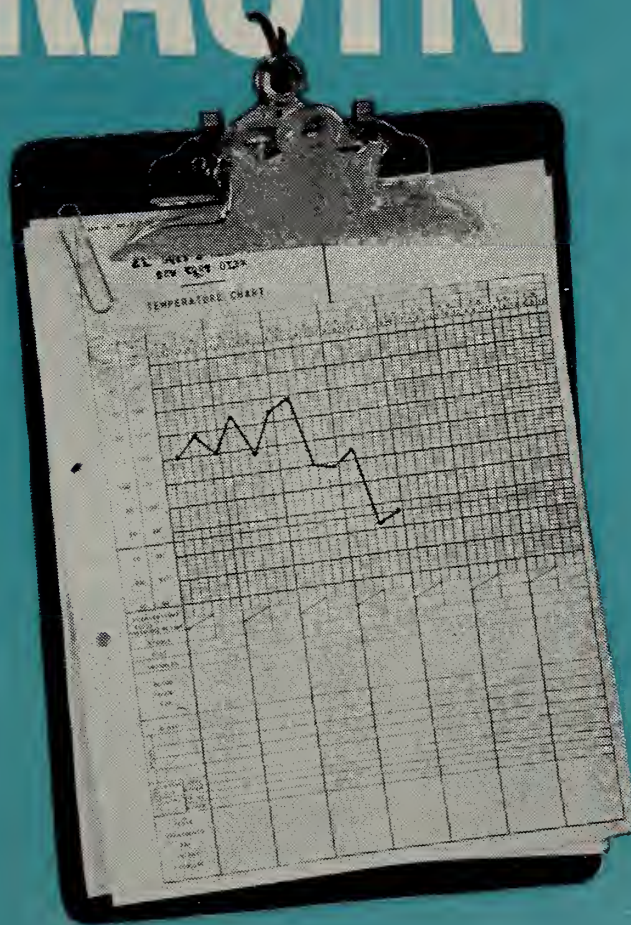
The public relations program was formulated at a special meeting presided over by Dr. Ash and attended by key officers and committee chairmen.

At the general meeting, Dr. Frank W. Anzinger, Jr., Society president, reported that a news release concerning distribution of polio vaccine

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by the Springfield Department of Health was made in the favorable interests of the Society.

Dr. Anzinger said this was made possible through the mutual cooperation of Dr. Joseph N. Hebble, city health director, and the Society.

The President also reported that the Society's efforts to effect a reorganization of the Springfield Diabetic Association, a lay organization, toward what is expected to result in a stronger, more active group, have been successful.

Guest speaker for the January meeting was Dr. Jerome Giuseffi, assistant professor of surgery, University of Cincinnati College of Medicine, whose topic was "Arterial Diseases and Blood Vessel Graftings."

DARKE

Dr. Robert Bruce, Dayton, spoke at the March 20 meeting of the Darke County Medical Society at the Greenville Country Club. His subject was, "Ophthalmology in General Practice."—Maurice Kane, M. D., secretary-treasurer.

MONTGOMERY

The Dayton Obstetrical and Gynecological Society met on March 21 at the Van Cleve Hotel in Dayton. Following a social hour and dinner, Dr. S. B. Gusberg, professor of obstetrics and gynecology, Columbia Presbyterian Medical Center, spoke on "The Choice of Treatment for Cancer of the Cervix."

The Dayton Surgical Society met on March 27 at the Van Cleve Hotel for a dinner meeting. A panel discussion was held on "Recent Advances in Medical and Surgical Treatment of Thyroid Disease." Guest speakers were Dr. Edwin H. Ellison, associate professor of surgery, and Dr. George Hamwi, associate professor of medicine, both of Ohio State University College of Medicine.

Third District

(COUNCILOR: JAMES R. JARVIS, M. D., VAN WERT)

AUGLAIZE

Physicians of Auglaize and Mercer Counties met on March 15 at Koch's Restaurant, St. Marys, for a joint dinner meeting.

In behalf of the Ohio State Medical Association, Dr. James R. Jarvis, Van Wert, Councilor of the Third District, presented Dr. Guy E. Noble, of St. Marys, with his 50-Year Pin. A practicing physician, Dr. Noble is chairman of the Board of Governors of the Joint Township Memorial Hospital, health commissioner of St. Marys and former Councilor of the Third District.

A discussion on anesthesia constituted the scientific part of the program.

Fourth District

(COUNCILOR: PAUL F. ORR, M. D., PERRYSBURG)

ERIE

The regular meeting of the Erie County Medical Society was held at Providence Hospital, March 22.

Preceding the business meeting, a film on "The

Use of Thorazine in Anesthesia," was shown through the courtesy of the local representative of the Smith, Klein & French Co.

Members were honored to have at the meeting, Dr. H. T. Pease, of Wadsworth, Councilor of the Eleventh District, who spoke on the subject of "Grievance Committees," explaining their purpose and answering questions.—S. R. Hoover, M. D., Secretary.

PUTNAM

The Putnam County Medical Society met at Hotel Dumont, Ottawa, on February 7. Guest speaker was Dr. P. A. Connaughton, Lima internist. His subject was "Some Newer Concepts in Liver Disease."—H. N. Trumbull, M. D., correspondent.

SANDUSKY

The Sandusky County Medical Society is now publishing a regular monthly news letter which goes to its members in mimeograph form over the signature of Dr. Richard R. Wilson, president.

On March 21 the Society met at Serwins Restaurant in Fremont for dinner and a meeting. The program was arranged by Dr. G. Walker, of Woodville, who introduced as guest speaker Dr. Fred Hawkins, of Toledo. Dr. Hawkins spoke on "Orthopedics in General Practice."

One of the matters which came out of the business meeting was a mutual agreement between the Society, the local and county health commissioners on a policy in regard to polio vaccine.

The Sandusky County Medical Society on April 18 sponsored a postgraduate series of lectures at the Moose Temple in Fremont which began in mid-afternoon, with a break for social hour and dinner and then continued into the evening.

A team from Ohio State University College of Medicine conducted the scientific program, with the following speakers and subjects:

Dr. Eldred B. Heisel, associate professor of medicine, "The Recognition of Common Skin Diseases," and "The Office Management of Common Skin Diseases."

Dr. John A. Whieldon, director of the Mental Hygiene Clinic and assistant professor of psychiatry, "Recognition and Treatment of the Neurotic Patient—a Practical Approach."

Dr. Robert F. Goldberg, instructor in medicine, "The Use and Abuse of Cortisone," and "The Role of Hormones in the Treatment of Cancer."

Dr. Harry E. Ezell, assistant professor of obstetrics and gynecology, "The Causes and Management of Prolonged Labor."

Fifth District

(COUNCILOR: GEORGE W. PETZNICK, M. D., CLEVELAND)

The regular meeting of the Academy of Medicine of Cleveland was held on March 16 at the Medical Library Auditorium. The program con-

sisted of late afternoon presentations, a social hour and dinner and a talk by the guest speaker.

The guest was Dr. Averill A. Liebow, professor of pathology, Yale University whose topic was "Observations on the Pulmonary Circulation."

The following Cleveland physicians spoke on the subjects indicated:

Dr. George Wright, "Alterations of Physiology by Mechanical Interference with the Airway."

Dr. Jerome Kleinerman, "Diffusion Problems: Alteration in Physiology of Ventilation and Circulation by the Pulmonary Fibroses (Granulomata)."

Dr. Sidney E. Wolpaw, "Treatment of Pulmonary Disorders Characterized by Interference with the Mechanical and Diffusion Aspects of the Respiratory Apparatus."

On March 16 the Experimental Medicine Section of the Academy met with the Cleveland Section of the Society for Experimental Biology and Medicine for a program.

Sixth District

(COUNCILOR: CARL A. GUSTAFSON, M. D.,
YOUNGSTOWN)

COLUMBIANA

Some 34 physicians attended a meeting of the Columbiana County Medical Society on March 20 at the Hotel Wick in Lisbon. A film on surgical

procedures previously shown on a nationwide television hookup was a feature of the evening.

Dr. J. K. Rugh, East Liverpool, president, conducted a business meeting. Dr. C. A. Gustafson, Youngstown, Councilor of the Sixth District, outlined aspects of the relationship between state and county medical organizations.

MAHONING

Dr. Samuel R. Gerber, Cuyahoga County coroner, told of his experiences as a medical sleuth at the second annual joint meeting of the Mahoning County Medical Society and the Mahoning County Bar Association March 22 at Youngstown Country Club.

Dr. Gerber showed color slides of a number of murder victims whose deaths at first appeared to be natural or accidental. The speaker's testimony in 1954 was important in the conviction of Samuel H. Sheppard for the murder of his wife.

Sixty-five physicians and 140 lawyers attended the meeting. Dr. G. E. DeCicco, president of the medical society, presided. Attorney Sidney Reigelhaupt, president of the bar association, spoke.

Dr. Gerber was introduced by Dr. David A. Belinky, Mahoning County coroner, who described the speaker as a "doctor, lawyer, investigator and philosopher." Dr. Gerber is an attorney as well as a physician.—From the *Youngstown Vindicator* and report by Dr. Clyde K. Walter.

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Youngstown Hospital Association gathered at South Side Hospital in Youngstown April 2 and dedicated a new auditorium, seating 200 and costing \$50,000, built for hospital-connected activities.

Among those who took part in the ceremonies were Dr. G. Gordon Nelson, past-president of the staff; Dr. W. K. Allsop, also a past-president of the staff; Dr. E. C. Baker, president of the staff, and Dr. R. W. Rummell. Dr. A. Earl Brant, another past-president, was scheduled to speak but was prevented by illness from being present.

SUMMIT

Dr. Edmund R. Novak, Johns Hopkins Hospital, spoke at the April 3 meeting of the Summit County Medical Society on "The Menopause." The meeting was held at the Akron General Hospital Auditorium preceded by dinner at the Akron City Club.

On March 6 the Children's Hospital gave a dinner at the Chesterfield Hotel to honor employees of long standing and present service pins. An outstanding event of the evening was presentation of a plaque to Dr. A. S. McCormick. The plaque reads: "The Children's Anesthesia Recovery Room is dedicated to Alexander Stearns McCormick, for continuous service to Children's Hospital and the children of the community since 1911." When the recovery room is installed a bronze tablet worded like the testimonial is to be placed on the wall.

Seventh District

(COUNCILOR: ROBERT HOPKINS, M. D., COSHOCTON)

TUSCARAWAS

With approximately 100 present, members of the Tuscarawas County Medical Society entertained members of their office staffs at a dinner sponsored March 21 at Union Country Club by the Auxiliary. The social gathering has been established as an annual affair and included dinner and an evening of entertainment.

Eighth District

(COUNCILOR: WM. D. MONGER, M. D., LANCASTER)

GUERNSEY

Dr. William Bryant was in charge of the program at the Guernsey County Medical Society meeting of March 1 in the Berwick Hotel, Cambridge. Dr. Bryant discussed the use of certain drugs, illustrating with film. Dr. Thomas Frame, president, conducted the business meeting.

Ninth District

(COUNCILOR: C. L. PITCHER, M. D., PORTSMOUTH)

SCIOTO

On March 12 the Scioto County Medical Society had as guest speaker Dr. Edwin Ellison, associate professor of surgery, Ohio State University, whose subject was "Ulcerogenetic Tumors

of the Pancreas." The program was arranged by Dr. R. W. Lewis.

Tenth District

(COUNCILOR: E. H. ARTMAN, M. D., CHILLICOTHE)

FRANKLIN

Dr. Paul H. Holinger, professor of bronchoesophagology at the University of Illinois College of Medicine, and senior attending bronchoesophagologist at St. Luke's Hospital and Children's Memorial Hospital in Chicago, was guest speaker at the April 16 meeting of the Columbus Academy of Medicine. His subject was "Management of Respiratory Obstructions."

ROSS

Dr. Harry Shirkey, associate professor of pediatrics, University of Cincinnati, was guest speaker at the March 1 dinner meeting of the Ross County Academy of Medicine. He discussed accidental poisoning of children. The guest speaker was introduced by Dr. Paul MacCarter and Dr. Charles N. Hoyt, president, presided at the business session.

Eleventh District

(COUNCILOR: H. T. PEASE, M. D., WADSWORTH)

MEDINA

The regular meeting of the Medina County Medical Society was held at the Lodi Community

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Hospital on March 15. The speaker was W. O. Rowland, Akron, who discussed the Ohio and Federal narcotic laws. Mr. Rowland is past-president of the Ohio State Pharmaceutical Association and Chairman of its committee on professional relations.

A business meeting preceded the address conducted by Dr. Richard Avery, president.

Attached to the monthly news letter of the Society for March was a summary of the communicable disease report for the county. Members were asked to tell whether or not they liked to have it.—W. G. Halley, M. D., secretary.

RICHLAND

Members of the Richland County Medical Society met at Mansfield General Hospital February 23. Dinner was served at 6:00 P. M., after which a business meeting was held, presided over by Dr. P. O. Staker, president.

The meeting was then turned over to the Program Committee, and the guest speaker, Dr. J. J. Jacoby from Ohio State University, who gave a very interesting and informative talk on "Cardiac Arrest."

A meeting of the Society was held at Mansfield General Hospital March 22. A business meeting was conducted by Dr. P. O. Staker, president, after which a very interesting talk on "Problems of Medical Education" was presented by Dr. William F. Ashe, Ohio State University, School of Medicine, Columbus.—Charles F. Curtiss, M. D., Secretary.

VA Announces New Open Ward Program For Certain Mental Patients

A successfully tested program at the Veterans Administration hospital in Albany, N. Y., is setting the pace for a new type "total push" program in other VA institutions. The program attempts to recondition selected long-term psychiatric patients from closed ward status in neuropsychiatric hospitals to open ward status in general VA hospitals.

Albany reported the following results in three years of working with approximately 350 chronic schizophrenics, some of whom had been hospitalized in closed wards of neuropsychiatric hospitals for as long as 35 years:

1. All patients live in open wards, in daily contact with non-mental patients.
2. Sixty have progressed to the point where they are working regularly at jobs in the hospital; and,
3. Fourteen at the time of writing had made trial visits home with 10 or more slated for similar pre-discharge privileges.

We're Sorry

In the April issue of *The Journal*, it was stated that the Odessa Medical Institute was located in Odessa, Russia. We have been advised that Odessa is located in Ukraina, one of the Socialist Soviet Republics, but not a part of Russia.



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Activities of Woman's Auxiliary . . .

CHAMPAIGN

One hundred girls from county and city schools were entertained by members of the Auxiliary of the Champaign County Medical Society early in February. A conducted tour of Mercy Memorial and Champaign County hospitals was made during the afternoon.

Assisting the Auxiliary with the tour were members of the Champaign County Nurses Association. The purpose of the tour was to acquaint the high school seniors who were interested in any phase of nursing with hospital techniques. Refreshments were served at the hospitals following the tour.

CLARK

A luncheon for the Woman's Auxiliary to the Clark County Medical Society was held on February 13 in Ker-Deen Inn. Mrs. J. M. Summers was hostess, assisted by Mrs. H. B. Elliott, Mrs. R. A. McLemore and Mrs. Charles Townsend. During the business session following the luncheon, the women organized their plans for the annual gardenia sale to promote nursing scholarships.

At the January meeting of the Auxiliary at the home of Mrs. R. J. Pospisil, spring hats were fashioned by various members. Mrs. M. H. Gerke was the hostess. Mrs. Starling Yinger was in charge of the program.

DELAWARE

The members of the Delaware County Medical Society were guests of the Woman's Auxiliary at their annual dinner meeting on Tuesday evening, February 21. Mrs. E. V. Arnold was hostess to the group at her home. A humorous version of a Medical Society Convention furnished the theme for decorations and entertainment for the evening. Arrangements for the evening were made by the program committee headed by Mrs. Tennyson Williams.

ERIE

Dr. Eldon T. Smith, director of student life and services at Bowling Green State University, was the speaker when the Woman's Auxiliary to the Erie County Medical Society entertained its guests for luncheon on March 5. "Midsummer Madness" was the title of his talk—a discussion of the development of "summer theatre" in the United States. Hostess for the guest day luncheon meeting was Mrs. H. L. Sowas, chairman, Mrs. W. R. Liebschner, Mrs. R. D. Fishell and Mrs. G. D. Stimson assisting.

Among the interesting happenings of the week of February 10, was the luncheon meeting of the Woman's Auxiliary to the Erie County Medical Society. An enjoyable entertainment feature served the dual purpose of raising funds for the American Education Foundation.

Pretty appointments for the affair at the Business Woman's Club on February 6 were in Valentine motif. The hostess committee trio was Mrs. Mrs. C. R. Swanbeck, Mrs. R. H. Williamson and Mrs. Malcolm Boylan. Mrs. Boylan, legislation chairman, reported on three bills before Congress having medical aspects.

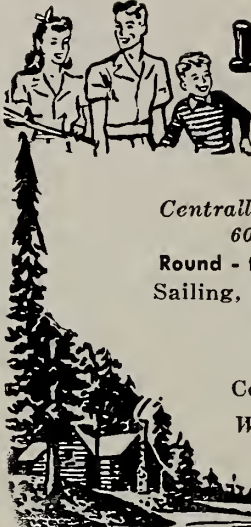
Chairmen of hospital service at Good Samaritan and Providence Hospitals reported that the bookmobile continues twice weekly rounds. Volunteers from the membership provide the "manpower" to push the carts through the corridors offering reading material to patients.

The Auxiliary voted to place a book in the library at the Providence Hospital School of Nursing in memory of the late Mrs. Elsie Schoepfle who passed away recently in California. She was the widow of Dr. Henry Schoepfle who formerly practiced medicine in Sandusky.

Another highlight of the afternoon was the traditional "silent auction," the Auxiliary's way of raising contributions to the American Medical Education Foundation.

FRANKLIN

The Woman's Auxiliary to the Columbus Academy of Medicine, with Dr. Gilman D. Kirk as



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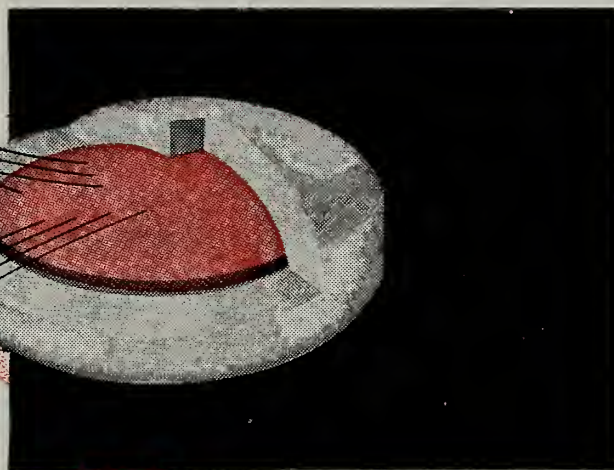
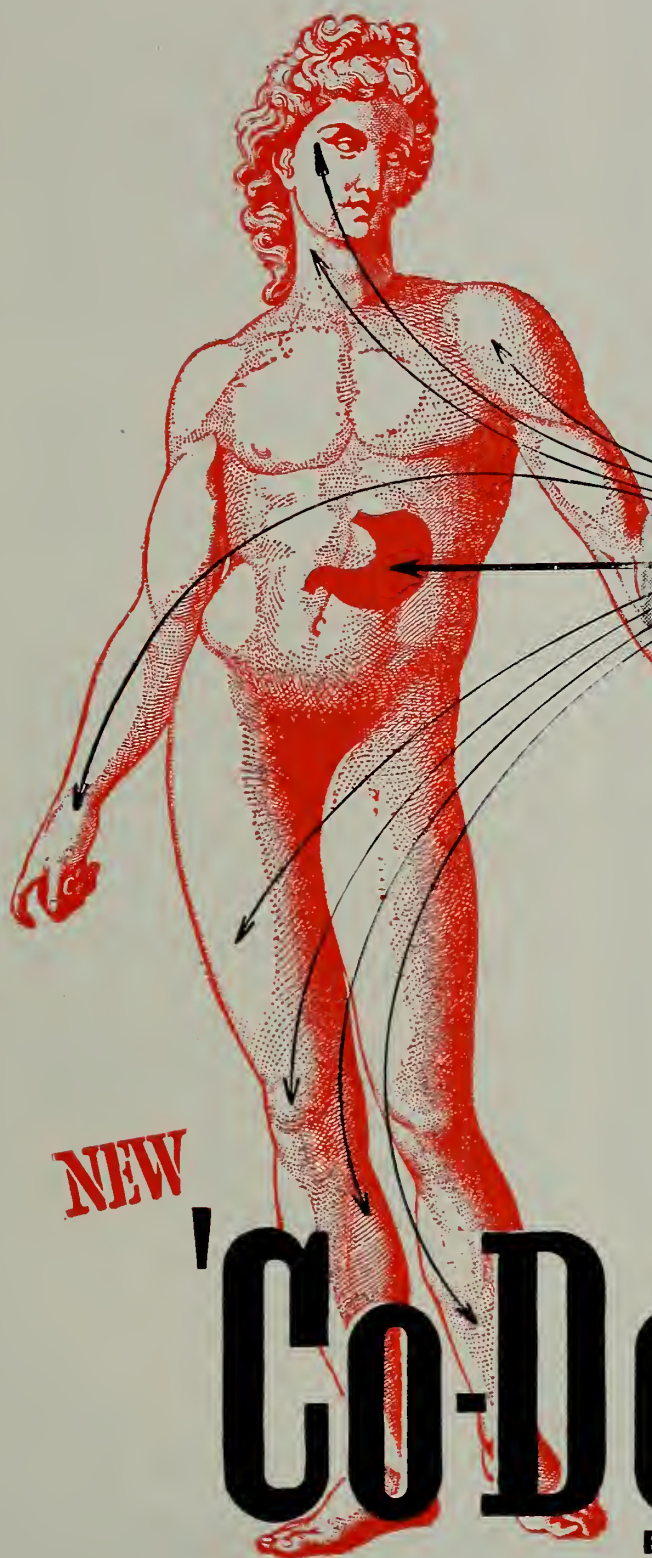
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speaker, met for the February meeting at the Columbus Gallery of Fine Arts. Dr. Kirk's topic was "Medicine from Yesterday to Tomorrow," and he was introduced by Mrs. Perry Ayres. Arrangements for the meeting were made by Mrs. Frank A. Reibel. Chairman of hostesses was Mrs. Karl Reichelderfer, assisted by members of the executive board.

GREENE

Speaking on "Civil Defense," Mr. F. E. Hill of Xenia advised members of the Auxiliary to the Greene County Medical Society to "be prepared for your own protection in the event of an attack." He addressed the group at a luncheon at Antioch Tea Room in Yellow Springs on February 10.

Mrs. Paul D. Espey of Xenia was named delegate to the convention of the Auxiliary of the Ohio State Medical Association in Cleveland; Mrs. Reid P. Joyce, alternate.

Reports of Auxiliary activities were given. The Visual Education Committee reported two films were screened recently for 800 pupils in Xenia Central, East, St. Brigid and Woodrow Wilson High Schools. The pictures were "Man Alive," released by the American Cancer Society, and "Prescription for Living," released by the American Red Cross in connection with its blood donor program. The Visual Education Committee has as co-chairmen Mrs. H. C. Messenger, and Mrs. Joyce; Mrs. Espey, Mrs. R. D. Hendrickson and Mrs. A. D. DeHaven assisted in the project.

The group voted to contribute \$10 to the American Educational Foundation fund. This gift was made in memory of the late Dr. R. Reyburn McClellan of Xenia. Two subscriptions to *Today's Health* will be provided by the Auxiliary for Greene Memorial Hospital where the group recently installed a television in the pediatric ward. The society also voted to defray expenses of a Christmas party for nurses at the hospital in December and agreed to assist in recruiting donors for a visit of the bloodmobile. Hostesses were Mrs. R. David Warner, of Xenia, Mrs. H. M. Berley and Mrs. Carl Hyde of Yellow Springs.

HARDIN

A record gathering of 145 students from six schools attended the fourth annual "Career Day" held February 16 at San Antonio hospital. The groups included 54 from Kenton, 40 from Forrest, 35 from Ada, nine from Roundhead, six from Mt. Victory and one from Dunkirk. A mother, Mrs. Frank Shaffer of Roundhead, also participated.

A lecture, tour of the hospital and refreshments were included on the program sponsored by the Woman's Auxiliary of the Hardin County Medical Society with Mrs. Glen Van Atta as chairman and Mrs. R. G. Schutte as registrar.

The monthly dinner meeting of the Hardin County Medical Auxiliary was held on February 14 in the dining room at San Antonio hospital with 17 members and two guests, Mrs. Donald

Ataractics and Holotherapy in MENTAL and EMOTIONAL DISORDERS

Already clearly historical are the major successes due to use of the new ataractics, or tranquilizers, in mental and emotional disorders. Still vital, however, to enduring, optimal remission in *all* such disorders is the assurance of *adequate* nutrition—a therapeutic and prophylactic *fundamental*. For, the nervous system, even with the aid of the most efficacious drug, simply cannot function normally unless adequately supplied with essential nutrient factors.

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*McLester, J. S., and Darby, W. J.: *Nutrition and Diet in Health and Disease*, ed. 6, Phila., Saunders, 1952, p. 195.

Vincent of Columbus, and Miss Ruth Lunney of Kenton present.

Miss Lunney was introduced as guest speaker for the evening and gave an interesting talk concerning her experiences as city health nurse.

During the business session, final plans were made for the annual nurse recruitment tea.

HAMILTON

Mrs. Herbert J. Brinker, president of the Woman's Auxiliary to the Hamilton County Medical Society, led the membership in honoring its past presidents at a luncheon on February 21 in the ballroom of the Hotel Alms.

The tribute was a timely one, as the Auxiliary observed the 15th anniversary of its founding.

A business meeting followed the program, which was conducted by Mrs. Brinker. Dr. Richard W. Vilter was the guest speaker at the luncheon and meeting. He gave his impressions of Egypt in the form of a medical travelogue. He was introduced by Mrs. I. C. Sharon.

HURON

On February 10, the Huron County Medical Auxiliary met at the DAR House in Norwalk for another business session and dessert luncheon. Mrs. Charles Edel, assisted by Mrs. A. H. Kimmel, was hostess.

Dr. Richard Waite, from the Tiffin Mental Hygiene Clinic, was the guest speaker.

KNOX

Reports on mental health and the Golden Age Club activities and an exhibition of nursing career portfolios featured the meeting of the Knox County Medical Society Auxiliary, February 29, in the home of Mrs. James McLarnan.

Mrs. Robert Eastman gave the report on mental illness, Mrs. John Drake exhibited the nursing portfolios, which will be placed in high school libraries in Knox County, and Mrs. Julius Shamsky reported on the Golden Age Club.

LUCAS

On February 21, at the Academy Building, the Woman's Auxiliary to the Lucas County Medical Society, held its February meeting. Mrs. W. LeRoy Bryant, program chairman, introduced a traveling twosome, Mr. and Mrs. Wayne Hiser, who showed movies and slides and commented on their recent trip to Iceland. Mrs. Carl Bayha and Mrs. Russell Wahl were chairmen of the hostesses.

Professor Harold Towe of the Political Science Department, Toledo University, gave a talk on Civilian Defense which preceded the "Medic" film at the previous meeting.

The annual dinner dance of the Academy of Medicine and its Auxiliary was held February 4 at the Commodore Perry Hotel. Mrs. Rolland E. Scherbarth and Mrs. Ernst Sternfeld were chairmen of the dance committee.

Lucas County delegates to the Ohio State Convention were named as follows: Mrs. C. J. A.



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MAHONING

About 350 Mahoning County high school girls attended the tea given February 21 by the Woman's Auxiliary to Mahoning County Medical Society to interest them in the nursing profession.

The gathering, an annual event, was held at St. Elizabeth's Hospital and featured a talk by Miss Ethel M. Hopkins, St. Elizabeth's Director of Nursing Education, and a film entitled "Nursing Needs You." A tour of the hospital followed and later tea was served. About 30 members of the Auxiliary were present.

MEDINA

The monthly meeting of the Medina County Medical Auxiliary was held February 21, in the Lodi State Band community room. A tea was given honoring the wives of pharmacists and dentists of Medina County. Mr. Arthur Wright of Wadsworth talked on "Civil Defense."

MIAMI

The Woman's Auxiliary of the Miami County Society met on February 7 at the residence of Mrs. Kurt Becker. The guest speaker was Mrs. E. J. Curtis, whose subject was "Skin Care and Tips on Make-up."

OTTAWA

The Ottawa County Medical Auxiliary met for its February meeting at the home of Mrs. C. R. Wood. The annual tea for the recruitment of nurses was the main topic during the business meeting. It was scheduled for April 24.

RICHLAND

A Valentine dinner party was held by members of the Woman's Auxiliary to the Richland County Medical Society for their husbands on February 16, at the Richland Recreation Center. Preceding dinner, Dr. and Mrs. Carl Damron and Dr. and Mrs. Carroll Damron were host couples for a cocktail party.

SCIOTO

Mrs. C. W. Wendelken will serve as president of the Woman's Auxiliary of Scioto County Medical Society in the coming year. Election of officers highlighted the Auxiliary's February meeting at the home of Mrs. Dow Allard.

Other new officers who will serve with Mrs. Wendelken are: Mrs. William C. Hugenberg, president-elect; Mrs. Robert B. Rardin, vice-president; Mrs. Jack MacDonald, secretary; Mrs. W. A. Ray, treasurer; and Mrs. George Martin, advisory board member.

Mrs. B. U. Howland, current president, announced a new radio program called "Your Health Reporter," with Mrs. Samuel Meltzer, chairman of radio and visual education, as the announcer.

Current medical legislation being considered by Congress was discussed by Mrs. Wells McCann, and Mrs. Louis R. Chaboudy reported on the

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origin and need for the American Medical Education Foundation.

The Auxiliary voted support to the Red Cross drive.

For the program, Mrs. Harry F. Rapp presented a paper on "Geriatrics" and the topic "Safety in the Home" was presented by Mrs. George E. Obrist.

SHELBY

The goals and aspirations regarding the workings of the Medical Auxiliary groups were discussed by Mrs. L. W. Sontag at the January meeting of the Woman's Auxiliary to the Shelby County Medical Society. Mrs. T. W. Hunter entertained the group in her home.

Mrs. Sontag, who resides in Yellow Springs, Ohio, is district director for the Auxiliary. She stressed the unit approach to program planning, with emphasis on a balanced program and with the channeling of activities and efforts to an area of accomplished reality.

The short business session was presided over by Mrs. John Conner, president of the group.

SUMMIT

Mrs. Laurence Wineberger, president of the Woman's Auxiliary to Summit County Medical Society, entertained the officers and board of the Auxiliary at luncheon in Akron City Club on February 3. Plans were discussed for the annual Health Days Exposition, sponsored by the Auxiliary in O'Neil's auditorium. Mrs. George Van Buren was chairman of the exposition, with Mrs. R. J. Hemphill as co-chairman. The purpose of the displays is to convey to the public the role played by community agencies in promoting better living through better health.

This is the ninth year for the exhibit sponsored by 275 doctors' wives who make up the membership of the Medical Auxiliary.

VAN WERT

Mrs. C. A. Morgan was hostess for the monthly meeting of the Van Wert County Medical Auxiliary on March 2. In a legislative report, Mrs. E. W. Burnes explained proposed medical bills.

Mrs. J. Cox, Auxiliary president, announced a notice of the TV program, "Out of Darkness," scheduled for March 13 with Dr. William C. Menninger in charge of the mental health program. *Great Adventures in Medicine* was reviewed by Mrs. J. R. Jarvis.

WASHINGTON

Mrs. Gerald Hamilton gave an interesting and informative talk on her recent trip to Europe for members of the Woman's Auxiliary to the Washington County Medical Society in the Betsey Mills Club parlors.

The program followed dinner. Mrs. R. H. Sloan, Mrs. Richard Hille, Mrs. T. R. Mattocks and Mrs. Shelby Jarrell were in charge of arrangements.

Mrs. W. S. Hawn presided for business in the

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*Moyer, J. H., and Hughes, W. M.:
J. Chron. Dis. 2:678, 1955.

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absence of Mrs. Donald Fleming. Reports were given by committees as follows: Mrs. I. J. Johnson announced that sales tax stamps collected had been packaged and readied for shipment to Columbus.

Mrs. Clarence Ash of the hospital committee announced that the croupette purchased by the Auxiliary had been received by the hospital and also that a high chair, purchased by the Auxiliary, had been delivered to the children's ward.

Mrs. Ford Eddy of the ways and means committee, announced plans for a rummage sale April 20.

Mrs. Sloan introduced Mrs. Hamilton who showed pictures taken in England, Norway, Denmark, Sweden and Germany during the past summer.

Division of Mental Hygiene Announces Appointments

Dr. Robert A. Haines, superintendent of the Apple Creek State Hospital, has accepted appointment as superintendent of the Longview State Hospital, Cincinnati, it was announced by Dr. Leonard P. Ristine, acting commissioner of the State Division of Mental Hygiene.

Dr. Haines will be succeeded at Apple Creek by Dr. William G. Stover, assistant superintendent of the Cleveland Receiving Hospital and State Institute of Psychiatry.

Dr. Haines succeeds Dr. E. A. Baber, superintendent at Longview for 33 years, who retired March 31.

Seminar for General Physicians on Venereal Diseases Is Planned In Cincinnati, May 17

With the shift of emphasis in diagnosis and management of venereal disease from clinics to physicians' offices, doctors in the vicinity will be interested in a one-day Venereal Disease Seminar to be held at the University of Cincinnati College of Medicine Auditorium on Thursday, May 17.

Dr. Ralph E. Dwork, director of the Ohio Department of Health, announced the program for the sponsoring organizations which are: The Ohio Department of Health, the Cincinnati and Hamilton County Health Departments, the Academy of Medicine of Cincinnati, the University of Cincinnati College of Medicine, the Southwestern Ohio Society of General Physicians, the Cincinnati Dermatological Society and the Cincinnati Social Hygiene Association.

Outstanding guest speakers include Dr. Evan Thomas, consultant in venereal diseases, New York State Department of Health, emeritus professor of clinical medicine (syphilology), New York University College of Medicine and formerly director of syphilis service at the Bellevue Hospital, and, Dr. Harold J. Magnuson, chief, Operational Research Section, Venereal Disease

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GYNECOLOGY—Office & Operative Gynecology, two weeks, June 18. Vaginal Approach to Pelvic Surgery, one week, June 11.

MEDICINE—Electrocardiography & Heart Disease, two-week basic course, July 9. Gastroscopy & Gastroenterology, two weeks, Sept. 10.

RADIOLOGY—Diagnostic X-Ray, two weeks, Sept. 17. Clinical X-Ray, two weeks, by appointment.

PEDIATRICS—Neurological Diseases: Cerebral Palsy, two weeks, June 18.

UROLOGY—Two-week course Oct. 8. Cystoscopy, ten days, by appointment.

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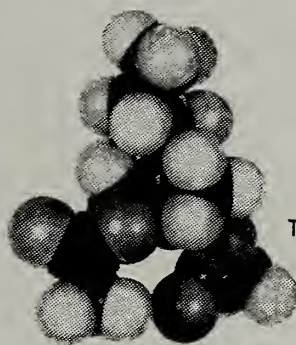
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Costs are being borne by the Ohio Department of Health and no tuition fee will be charged. Postgraduate credit of 4½ hours, Category II, has been approved by the Ohio Academy of General Practice.

The program has been announced as follows:

MORNING SESSION

Dr. Charles Sebastian, President of the Academy of Medicine of Cincinnati, presiding.

8:45 - 9:00 a.m.—Registration

9:00 - 9:15—Welcome by Dr. Sebastian and Dr. Carl A. Wilzbach, Cincinnati health commissioner.

9:15 - 9:45—"The Current Status of Gonorrhea," Dr. Ira Schemberg, chief, venereal disease program, Department of Public Health, Philadelphia, Pa.

10:00 - 11:15—"Diagnosis and Management of Syphilis in General Practice Today," Dr. Thomas.

11:15 - 12:00 noon—"Laboratory Aspects of the Diagnosis of Syphilis," Dr. Magnuson.

12:00 noon - 1:15 p.m.—Luncheon, Cafeteria.

AFTERNOON SESSION

Dr. Wilzbach, Presiding.

1:15 - 1:45 p.m.—"Non Venereal Lesions of Genitalia and Mucosae," Dr. Alfred L. Weiner, assistant professor of dermatology and syphilology, University of Cincinnati College of Medicine; director, Venereal Disease Clinic, Cincinnati General Hospital, and consulting dermatologist and syphilologist, Cincinnati Health Department.

1:45 - 2:15—"The Status of Venereal Disease in Ohio Today," Dr. Frederick H. Wentworth, chief of the Division of Communicable Diseases, Ohio Department of Health.

Hospital Construction Drops

Data published by U. S. Commerce and Labor Departments disclose that while national expenditures for all new construction in first two months of 1956 were slightly ahead of same period in 1955, hospital and institutional projects dropped markedly. Outlay for private hospital and institutional construction was estimated at \$51 million, compared with \$56 million a year ago, or a decline of 9 per cent. For public projects of same type, the drop was greater—from \$47 million to \$42 million, or 11 per cent. For February alone, public hospital and institutional construction totaled \$19 million, a 14 per cent decline from February, 1955. Corresponding figure for private hospitals and institutions was \$25 million, off 11 per cent from a year ago.

INDEX TO ADVERTISERS

American Meat Institute	468
Ann Arbor School	544
Appalachian Hall	475
Ayerst Laboratories, Inc.	525
Bayer Company, The Div. of Sterling Drug Co., Inc.	553
Burroughs Wellcome & Co. (U. S. A.) Inc.	552
Ciba Pharmaceutical Products, Inc.	548
Cincinnati Sanitarium	461
Cook County Graduate School of Medicine	544
Davies, Rose & Co., Ltd.	537
Foot-so-Port Shoe Co.	542
Gallagher-Roach & Company	519
General Foods Corporation (Sanka)	550
Harding Sanitarium	474
Hoffmann-LaRoche, Inc.	Insert between pages 520 - 521
Knox, Chas. B., Gelatine Co., Inc.	549
Lakeside Laboratories, Inc.	457, 513, 543
Lederle Laboratories	510 - 511
Lenape Village	538
Lilly, Eli, and Company	480
Luzier's, Inc.	475
Magnetic Springs Foundation	555
Mallard, Inc.	541
Manitowaning Lodge	508
McMillen Sanitarium	474
Medical Protective Company	543
Neil Training School	547
New York Polyclinic Medical School	521
Pablum Products Div. of Mead Johnson & Co.	554
Parke, Davis & Company	462 - 463; 556 and Inside Back Cover
Pfizer, Chas. & Co., Inc.	467, 533
Picker X-Ray Corporation	479
Pogue, Mary, School, Inc.	466
Quincy X-Ray & Radium Lab.	536
Rocky Glen Sanatorium	521
Sawyer Sanatorium	477
Schering Corporation	476 and Insert between pages 476 - 477; 517, 531
Scroggins, Clayton L., Associates (Medical-Dental Management)	548
Searle, G. D. & Company	515
Sharp & Dohme, Inc.	464 - 465; 473, 523, 539
Smith, Kline & French Laboratories	551 and Back Cover
Squibb, E. R. & Sons, Division of Olin- Mathieson Chemical Corporation	478
Stoneman Press	466
Training School at Vineland, N. J., The	538
Tutag, S. J. & Company	555
Upjohn Company	469, 527
Vitamin Food Co., Inc.	540
Wallace Laboratories	545
Wendt-Bristol Company	542
Wesnoca	536
Wickhaven Sanitarium	521
Windsor Hospital, Inc.	466
Winthrop Laboratories	459
Wyeth, Inc.	529, 535

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Physicians seeking locations in Ohio are invited to contact the Physicians' Placement Service in the executive offices of the Ohio State Medical Association, 79 E. State St., Columbus 15. Through this medium efforts are made to establish communications between physicians seeking locations and communities where physicians are needed, or other physicians who are in need of associates.

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GENERAL PRACTITIONER, many years hospital experience in dermatology, pediatrics and psychiatry, own private practice, desires association or assistantship or position in industrial or insurance medicine. Larger city preferred. Box 869, c/o Ohio State Medical Journal.

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The Secretariat of the World Medical Association and the United States Committee, Inc., is scheduled to move on May 1 to a suite of offices in the Coliseum Tower Office Building at 10 Columbus Circle, New York 19, N. Y. The Coliseum, now being completed, in addition to providing office space, was planned to accommodate large organizational meetings.

The largest enrollment growth since 1950 was recorded by Blue Cross Plans during 1955—3,726,899. At the end of 1955, total Blue Cross enrollment was recorded at 51,329,940 people.

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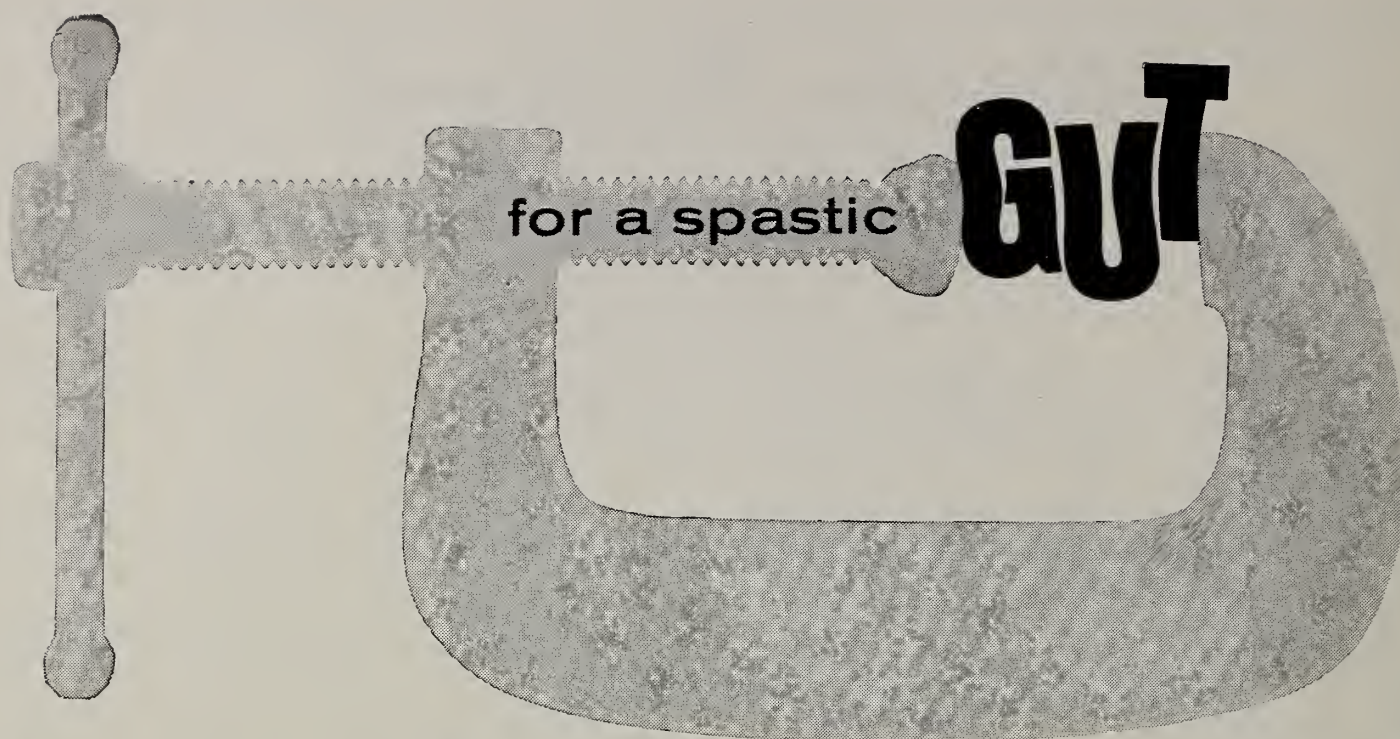
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The Physician's Bookshelf

By JONATHAN FORMAN, M. D.

Antimetabolites and Cancer, edited by Cornelius P. Rhoads, (\$5.75, Publication of *The American Association for The Advancement of Science, Washington 5, D. C.*). This is a symposium presented at the meeting of the Association, by 21 distinguished authorities on various phases of antimetabolism.

Cardiac Emergencies and Heart Failure—Prevention and Treatment, by Arthur M. Master, M. D., Marvin Moser, M. D., and Harry L. Jaffe, M. D., (\$3.75. 2nd Edition. *Lea & Febiger, Philadelphia 6, Pa.*). The chapters on congestive failure, arrhythmias, acute coronary disease, rheumatic heart disease, and hypertensive crises, have been revised and enlarged. In the three years since the first edition, a number of new drugs have been introduced to meet the cardiac emergencies, and these have been given thorough treatment. This book is kept in pocket size, so that it can be available at all times.

Problems of Consciousness; Transactions of the Fifth Conference, edited by Harold A. Abramson, M. D., (\$3.50. *Josiah Macy Jr., Foundation, Packanack, N. J.*). These transactions deal with the three dimensions of emotion, anxiety, the role of the cerebral cortex and anesthetics.

Surgery of the Ambulatory Patient, by L. Kraeer Ferguson, M. D., (\$12.00. *J. B. Lippincott Company, Philadelphia, Pa.*). This is a complete guide to this vast field. It has done much to help the general practitioner build a rewarding practice. The lesions discussed are those which are met regularly in the office, and an effort has been made to describe the best method of treating them as proved by the author's personal experience.

Clinical Roentgenology, Volume 3, The Lungs and Cardio-Vascular System, by Alfred A. de Lorimier, M. D., Henry G. Moehring, M. D., and John R. Hannan, M. D., (\$20.50. *Charles C. Thomas, Publisher, Springfield, Ill.*). This book has been organized and written with practical clinical usage uppermost in mind. While complicated technical procedures are discussed, the emphasis throughout is on every-day clinical diagnostic methods. A number of differential tables in this volume deal with such things as pulmonary cavitation, pseudocavitation, pulmonary nodules, abnormally prominent pulmonary markings, and segmental pulmonary densities.

Wise and Otherwise, by Maurice D. Sachnoff, M. D., (\$2.50. *Pageant Press, New York 36, New York*). This is an alphabetically arranged collection of epigrams and maxims, both light and serious, but always penetrating.

Jungle Doctor of Tanganyika, by Paul White, M. D., (\$3.00. *William B. Eerdmans Publishing Company, Grand Rapids, Michigan*). This is the personal story of a 25-year old medical missionary who fought sickness, disease, ignorance and superstition in the Central Plains of East Africa.

Jungle Doctor Meets a Lion

Jungle Doctor Attacks Witchcraft

Jungle Doctor's Enemies, by Paul White, M. D., (\$1.50 each. *William B. Eerdmans Publishing Company, Grand Rapids, Michigan*). These are three of the eleven books now in the series that Paul White, the medical missionary, has written about his experiences in Tanganyika Territory. His adventures and his lovable African converts make an appealing story of the missionary doctor and his enterprises.

The Care and Feeding of Twins, by Phyllis Graham, (\$3.50. *Harper & Brothers, New York 16, New York*). This is a book based on the personal experiences of the author. It is the first book written on this subject. The problem of two children of the same age is more than the problem of one child doubled. The interplay between the two new personalities is discussed and also the little-understood facts, fancies and folklore about twins. This makes the book of great benefit to the parents and relatives of twins.

Aids to Surgical Anatomy, by D. B. Moffatt, M. D., and J. T. Baxter, M. D., (\$2.75. United States Distributor, *Williams & Wilkins Company, Baltimore 2, Md.*). This is a carefully revised text of one of those delightful little manuals which the British publish as aids to the medical student.

Magic and Schizophrenia, by Geza Roheim, (\$4.50. *International Universities Press, New York 11, N. Y.*). This is a posthumous work. In it the author brings to bear the knowledge of anthropology and psychoanalysis, to the central topic of the relationship of magic and schizophrenia. The first part of the book deals with the various myths and folk tales which men in all parts of the world have evolved to allay their basic anxieties. The second part consists of the dreams and fancies of a schizophrenic patient, which bear striking relationship to the primitive myths.

The Plasma Proteins in Pregnancy, a Clinical Interpretation, by Harold C. Mack, M. D., (\$3.75. *Charles C. Thomas, Springfield, Ill.*). This is a monograph in the American Lecture Series. Over the years a long series of fundamental studies relating to mother and child metabolism have

come from the Children's Foundation of Michigan. The present monograph, dealing with this important and timely phase of the subject is, as Doctor N. J. Eastman says in his foreword: "a noteworthy addition to this distinguished record of achievement."

Clinical Psychiatry, by W. Mayer Gross, M. D., Elliot Slater, M. D., and Martin Roth, M. D., (\$10.00. *Cassell & Company, Ltd., London, England. United States Distributor, Williams & Wilkins Company, Baltimore 2, Md.*). The authors explain that during the decade before the second World War a considerable amount of work on the incidence, genetics, and pathology of mental disorder, and on the methods of physical treatment was published, both in the English-speaking world and in Central European countries. Much of this has never been reviewed, and it should certainly be considered from the clinical point of view, with the aim of assimilating it into the general body of knowledge. It is with this purpose in mind that the authors have given us this new text in psychiatry.

Intestinal Obstructions; Physiological, Pathological and Clinical Considerations with Emphasis on Therapy, Including Descriptions of Operating Procedures, by Owen H. Wangensteen, M. D., (\$15.50. 3rd Edition. *Charles C. Thomas, Publisher, Springfield, Ill.*) This is the first revision of this book in 15 years. The text has been increased by 364 pages and 70 additional illustrations. In view of the author's wide experience and recognized authority, this is a book that must be in the library of all students of surgery.

Nutrition for Practical Nurses, by Phyllis S. Howe, (\$2.50, paper. *W. B. Saunders Company, Philadelphia 5, Pa.*). This is addressed to a group of women who have not participated recently in formal academic study, and it endeavors to present the basic principles of nutrition and dietetics in a wise and elementary manner. The vocational nurse will thus be helped.

Meeting the Costs of Medical Care, by Robert M. Cunningham, Jr., (\$0.25. *Public Affairs Pamphlet #218. Public Affairs Committee, Inc., New York 16, N. Y.*). This pamphlet was written by the former editor of *Modern Hospital* and is a report on the methods used in the United States today.

The Family of Man, edited by Jerry Mason, published for the Museum of Modern Art, (\$1.00. *Maco Magazine Corporation, 480 Lexington Avenue, New York, N. Y.*).

Peptic Ulcer, Diagnosis and Treatment, by Clifford J. Barborka, M. D., and E. Clinton Texter, Jr., M. D., (\$7.00. *Little, Brown & Company, Boston 6, Mass.*). This is a handbook which correlates the latest developments on the subject. Emphasis is placed on the patient-physician re-

lationship, thereby improving results and preventing recurrence. The organization of the book is such that each chapter can be read as an independent essay on that phase of the peptic ulcer problem. The appendix, with its recipes and sample menus is significant and practical.

Psychiatry for the Family Physician, by C. Knight Aldrich, M. D., (\$5.75. *McGraw-Hill Company, Inc., New York, N. Y.*). This book is designed to provide the initial background for the study of the systemic knowledge and theory of human behavior and its modifications. It is divided into three books—Emotions in Illness, Emotional Development, and Diagnosis and Treatment.

Allergy Cooking—A Guide with Menus and Recipes, by Marion Conrad, (\$5.00. *Thomas Y. Crowell Co., 432 Fourth Avenue, New York 16, New York*). Deals with family adjustments to food allergy in a member. Hidden troubles—problems of eating out for food allergy sufferers at parties, picnics and camping; babies' and children's allergies; reducing and gaining weight on allergic diets; basic diets, their modifications, with scores of recipes.

Histamine: Its Role in Anaphylaxis and Allergy, by M. Rocha e Silva, M. D., (\$7.50. *Charles C. Thomas, Publisher, Springfield, Ill.*). This book is for clinicians, investigators and students. It contains chapters on free and bound histamine, liberation of histamine in physiological and pathological conditions, metabolism of histamine, the autopharmacological problems of anaphylaxis and allergy, inhibition of histamine effects, sensitization diseases. This is the first interpretive review of the biological significance of histamine in 25 years—none since Ferlberg's German text (1930).

French's Index of Differential Diagnosis, edited by Arthur H. Douthwaite, M. D., (\$20.00. 7th Edition. *Williams & Wilkins Company, Baltimore 2, Md.*). This standard text with its 731 illustrations of which 200 are in color, adds much to the book. The volume remains unique; is so for its differentiation of man's symptoms and its usefulness as a desk reference for the busy practitioner.

The Great Mother: An Analysis of the Archetype, by Erich Neumann, (\$7.50. *Pantheon Books, Inc., New York 14, N. Y.*). This is No. 47 in a series of works sponsored by and published for the Bollingen Foundation. When analytical psychology speaks of the archetype of the Great Mother, it is referring to an inward image at work in the human psyche. The effect of this archetype can be followed through the whole of history in the relics, myths, symbols of early man and also in the dreams, fantasies and creative works of the sound as well as the sick man of our day. In this text we have an elaborate exposition of the Great Mother in art and culture of Mankind.

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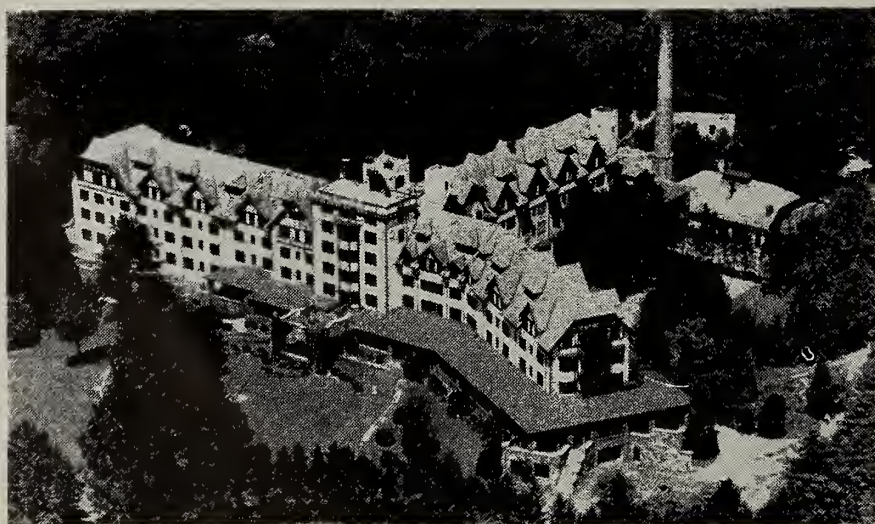
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The Ohio State Medical Journal

Published under the direction of The Council for and by the members of The Ohio State Medical Association, a scientific society, non-profit corporation, with a definite membership, for scientific and educational purposes.

Vol. 52

June, 1956

No. 6

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Angina Decubitus: A Clinical Appreciation

JOHN S. WATSON, M. D.

THE purpose of this paper is to present the histories of four patients who had angina decubitus, to discuss the clinical findings characteristic of the disease, to review the literature and present the treatment most effective in controlling these episodes.

CASE REPORTS

Case 1. A 45 year old white man, a boiler maker's helper, was first seen July 17, 1950, with the chief complaint of substernal pain. The first episode of substernal pain occurred July 19, 1949. The patient was seen by a physician and a diagnosis of coronary artery disease was made. He had experienced three similar episodes of substernal pain during July, 1949, the pain on each occasion being experienced during the night while in the recumbent position. From July, 1949, to July 17, 1950, the patient was working hard and in excellent health until the presenting episode of substernal pain brought him to see the author.

Past history, family history and systemic review were noncontributory.

Examination revealed an extremely well developed and well nourished white man who did not appear ill. His height was 74½ inches; weight 252 pounds. Temperature, pulse, respirations and blood pressure were normal. Eye ground examination was normal. No abnormalities of the heart and lungs were noted. There was no clinical evidence of aortic stenosis or aortic insufficiency. Abnormal examination was within normal limits, as was examination of the extremities.

The clinical impression was coronary artery disease and he was advised to have an electrocardiogram. He was given phenobarbital for sedation.

The patient called July 30, 1950, and stated he had an episode of severe pain subinternally at 3:30 a.m. which persisted for 45 minutes and had been relieved by phenobarbital. He called again on August 10 and stated he had another

The Author

● Dr. Watson, Columbus, is a member of the senior attending staff, White Cross Hospital; instructor, Department of Medicine, The Ohio State University College of Medicine.

episode of substernal pain at 3:00 a.m., which had persisted for 10 minutes. In addition to coronary artery disease: pancreatic disease, parasophageal diaphragmatic hernia, hypoglycemia, and abnormality of the vertebrae were considered as the cause of his nocturnal episodes of chest pain which always occurred in the recumbent position.

However, August 20, 1950, the patient was seized with another attack of severe pain subinternally which, for the first time, was associated with shortness of breath. This pain was continuous and persisted until he was given morphine sulfate. Complete blood count, sedimentation rate (corrected) and blood sugar were normal. Blood Wassermann and Kahn tests were negative. An electrocardiogram revealed ST segment changes suggestive of acute coronary artery insufficiency.

The appearance and activity of the patient during the attack was interesting. He was extremely active, walking around, swinging his arms back and forth, folding them over his chest and taking long deep breaths and then holding his breath. He stated that he felt exceedingly warm and examination revealed the upper portion of the body and especially the face to be an intense red color. The skin was unusually warm to the touch. Perspiration was not prominent. He was not cyanotic nor ashen grey as might be expected in angina pectoris of effort or acute myocardial infarction. The blood pressure was 100 systolic and 76 diastolic. The pulse was 100 but otherwise not unusual. Nitroglycerin admin-

Submitted September 23, 1954.

istered sublingually gave partial relief for a short time.

Hospitalization was refused and the patient was maintained at home at complete bed rest with medication for sedation.

August 20, 1950, while at complete bed rest, the patient experienced another episode of severe pain substernally and was admitted to the hospital where serial electrocardiograms showed anterolateral myocardial infarction. He was kept at bed rest, received anticoagulant therapy and a sodium free diet for a period of four weeks following which he was discharged to his home. He was not given a low sodium diet on discharge from the hospital although he was advised to restrict his activities and continue the reducing diet which he had been given while in the hospital.

September 21, 1950, he was awakened from his sleep by severe pain substernally and was readmitted to another hospital where electrocardiograms revealed evidence of an old anterior myocardial infarction without evidence of recent activity. He was discharged after a period of six days and received a sodium free diet on discharge. He has not had a recurrence of the substernal pain and has returned to his previous occupation. It is to be noted that when the patient was taken to the hospital for the second admission, his story of severe substernal chest pain always occurring while recumbent was not accepted by the admitting physicians and the patient was labeled a "neurotic."

Several things characteristic of angina decubitus in the foregoing case report were noted. The nocturnal (recumbent) nature of the episodes, the prolonged duration, the vasomotor phenomena, the activity of the patient and the ineffectiveness of nitroglycerin were striking. The relationship of the attacks to the presence of sodium in the diet was apparent. There was no clinical evidence of aortic valvular disease. In addition, there was great hesitancy in diagnosing coronary artery disease early in the course of the patient's illness and on the second admission to the hospital he was labeled a "neurotic."

He was last seen January, 1954, over 40 months following his episode of myocardial infarction and had been working hard with no symptoms referable to his cardiovascular system.

Case 2. A 77 year old housewife known to have hypertensive (systolic) heart disease and coronary artery insufficiency, (clinically angina pectoris of effort) was first seen in December, 1950. For seven years she had required a large number of nitroglycerin tablets on exertion, but for three years prior to the present illness the patient had not required nitroglycerin, apparently due to a marked restriction of her activities.

In December 1950 and January 1951, the patient suffered many episodes of substernal pain with radiation into the neck, left shoulder, and left arm. It was noted that the substernal pain always occurred while the patient was in the recumbent position, whether resting in bed during the daytime, or at night when she was asleep.

Past history, family history and systemic review were noncontributory.

Examination revealed an elderly, obese, white woman in no distress. The blood pressure was 200 systolic over 70 to 80 diastolic in each arm. Funduscopic examination revealed Grade I arteriosclerotic changes. Examination of the heart

revealed it to be enlarged to the left and downward. A Grade II, medium pitched, blowing systolic murmur was heard throughout the precordium. There was no clinical evidence of aortic valvular disease. Auricular fibrillation was present with a ventricular rate of approximately 80 to 90 per minute. There was no evidence of congestive heart failure.

Several electrocardiograms showed "a left ventricular strain pattern."

It became more difficult for the patient to relieve the episodes of substernal pain with nitroglycerin and on occasion morphine sulfate was required. She was seen many times during these episodes and there was no apparent change in the blood pressure or pulse. The substernal pain always occurred while the patient was at bed rest and she would insist on getting out of bed and walking about to relieve the pain. There was no evidence of cyanosis or ashen grey color.

Electrocardiograms taken following these episodes revealed no changes over those taken previously.

Since the patient had been given digitalis previously and the ventricular rate was well controlled, she was given mercurial diuretics and a sodium free diet. After following this regimen for several weeks, the patient became relatively and finally completely free of chest pain while in the recumbent position. She did not require the use of nitroglycerin.

In April 1951 the patient developed an episode of vaginal bleeding and was admitted to the hospital where a biopsy of the cervix revealed the presence of squamous cell carcinoma. Since the patient and her family refused any type of treatment either for the vaginal bleeding or the carcinoma of the cervix her course was progressively downhill until she expired April 22, 1951. Autopsy permission was not granted.

Several things characteristic of angina decubitus in the foregoing case report were noted. The nocturnal (recumbent) nature of the substernal pain, the prolonged duration, the ineffectiveness of nitroglycerin in relieving the episodes along with a marked overactivity of the patient were characteristic. Vasomotor phenomena were not observed in this patient and there was no change in the patient's pulse or blood pressure during the episodes. Repeated electrocardiograms revealed "a left ventricular strain pattern." It was apparent that the angina decubitus was closely associated with the patient's ability to follow her sodium free diet along with the liberal use of mercurial diuretics as an adjunct in the elimination of sodium and water from the body. Again, there was no clinical evidence of aortic valvular disease.

Case 3. A 68 year old white salesman known to have diabetes mellitus which was well controlled by diet and insulin was seen October 3, 1951, stating that he had several episodes of "indigestion." Indigestion was described as substernal pain of several minutes to hours duration which always occurred while he was in the recumbent position. He stated that he was unable to lie down after the pain had started and found it necessary to get up and "exercise" to relieve the pain. He denied any radiation of the pain and there was no nausea or vomiting. Shortness of breath was not noted nor was peripheral edema observed. The patient attributed his "in-

digestion" to food that he had eaten the evening previously.

Examination was not unusual with the exception that there was some evidence of systolic hypertension as manifested by a blood pressure of 150 to 160 systolic over 60 diastolic in each arm. There was no clinical evidence of aortic valvular disease.

An electrocardiogram revealed the presence of acute coronary artery insufficiency.

The patient was seen October 12, 1951, nine days later, when he was complaining of substernal pain with radiation into the left arm whenever he resumed the recumbent position. There was no shortness of breath. No nausea or vomiting. Examination revealed no evidence of congestive heart failure. On the evening of October 12, 1951, while sitting quietly watching television, he was seized with severe pain substernally which radiated into the left shoulder and inner aspect of his left arm. For the first time he noted shortness of breath but no nausea or vomiting. He did not perspire. The pain persisted until he was given morphine sulfate.

Examination revealed the temperature to be normal, pulse 88, and the blood pressure was 106 systolic over 64 diastolic. Respirations were 18 per minute. Examination of the heart and lungs revealed no abnormalities. There was no clinical evidence of aortic valvular disease, or congestive heart failure.

The clinical impression was angina decubitus complicated by acute myocardial infarction in a man known to have diabetes mellitus controlled with diet and insulin. He was maintained at complete bed rest, given morphine sulfate and was advised to discontinue the use of sodium in his diet. The following day he was very apprehensive and said that he was having an occasional twinge of pain substernally. An electrocardiogram revealed evidence of acute coronary artery inadequacy with probable anterolateral myocardial infarction. He was admitted to the hospital at 2:30 p.m. October 13, 1951. He had no complaints and was resting comfortably in bed when at 6:30 p.m., the day of admission to the hospital, the patient expired unexpectedly. Autopsy permission was not granted.

Several things characteristic of angina decubitus in the Case 3 report were noted. The substernal pain always occurred at night or while the patient was in the recumbent position. Prior to his expiration the patient stated that he had been able to do extremely hard work during the day without any discomfort in his chest. At no time did he complain of substernal pain or shortness of breath on exertion. The patient felt certain that exercise during the day gave him relief from the "indigestion" which he experienced at night. Nitroglycerin gave slight relief of short duration. Unfortunately it was not possible to determine the effects of the low sodium diet or mercurial diuretics in this patient prior to his death. Also, a description of the patient's activity and facial features was not obtained during the episodes of "angina decubitus."

Case 4. A 62 year old white salesman was first seen March 24, 1952, with a history of substernal oppression on exertion of three to four years' duration. Several physicians had diagnosed his condition as "angina pectoris of effort." Recently the patient had experienced

several episodes of pain substernally which always occurred at night while in the recumbent position. At one time the nocturnal episode of substernal pain persisted for 90 minutes.

Examination revealed the temperature, pulse and respirations to be normal. The blood pressure was 130 systolic over 90 diastolic in each arm. Examination of the heart and lungs revealed no abnormal findings. There was no clinical evidence of aortic valvular disease or congestive heart failure. An electrocardiogram was normal.

The clinical impression was coronary artery disease, angina pectoris of effort, and angina decubitus.

He was advised to restrict his activities to the point where substernal distress was not experienced. A low sodium diet was administered and he was given phenobarbital for mild sedation. Nitroglycerin was to be used sublingually as needed for substernal distress.

At 3:00 a.m. March 27, 1952, three days after the patient had been examined he was awakened by an episode of severe pain substernally and before he could obtain his nitroglycerin tablets fainted.

Examination at his home revealed an extremely apprehensive individual who was ashen grey in color. The pulse was 110 per minute, and the blood pressure was difficult to obtain although the sounds were heard at 90 millimeters of mercury. Oxygen was administered and the patient was admitted to the hospital at 4:00 a.m. March 27, 1952, with the clinical impression of "acute myocardial infarction."

After complete bed rest and the administration of oxygen the patient's color returned. The pulse and blood pressure were normal. Serial electrocardiograms revealed no electrocardiographic evidence of acute myocardial infarction. Complete blood count and sedimentation rate were normal. The patient was discharged four days later with the advice to restrict his activities and eliminate sodium from his diet. He has returned to his previous occupation as a salesman and has had no further difficulty with substernal distress while in the recumbent position. He does experience substernal distress on exertion which is relieved by rest and nitroglycerin. Repeated electrocardiograms have remained normal.

Although this patient presented many findings indicative of angina pectoris of effort and angina decubitus, it appeared that the admitting clinical diagnosis was that of acute myocardial infarction. This was not substantiated by clinical laboratory data. The effects of nitroglycerin were not demonstrated. The low sodium diet appeared to be effective in controlling the nocturnal episodes of substernal pain. This patient was seen in January, 1954, more than a year following his initial episode, and has been working without any apparent difficulty.

This patient received heparin intravenously in view of the literature suggesting its effectiveness in coronary atherosclerosis. It is, of course, impossible to make any statement regarding the value of heparin at this time.

REVIEW OF THE LITERATURE

If one examines the modern text of cardiovascular diseases published today, the paucity

of information regarding angina decubitus is immediately apparent.

Freidberg¹ summarizes in the following statement:

"There are true instances of angina pectoris occurring at night in patients at rest with or without paroxysmal dyspnea. Acute left ventricular dilatation, elevation of blood pressure, tachycardia and consequent increased work of the heart have all been invoked to explain the occurrence of this angina pectoris, so-called angina decubitus, but the actual cause remains obscure. It does appear that while chronic left and right sided congestive heart failure tend to dispel or diminish attacks of angina pectoris, acute left

TABLE 1. DIFFERENTIAL DIAGNOSIS (PARTIAL) BETWEEN ANGINA DECUBITUS, ANGINA OF EFFORT, AND MYOCARDIAL INFARCTION

	Angina Decubitus	Angina of Effort	Myocardial Infarction
Recumbent (nocturnal)	Always	Never	Equivocal
Duration	Prolonged	Brief	Prolonged
Activity	Increased	Absent	Not usual
Subjective phenomena	Warm & flushed	Usually cold	Cold & clammy
Objective phenomena	Flushed skin	Pallor	Shock-like state
Blood pressure	Often increased	Unchanged usually	Usually falls
Pulse	Often increased	Unchanged usually	Equivocal
Low sodium diet	Good response	No response	Usually none
Diuretics	Good response	No response	Usually none
Nitroglycerin	Equivocal	Pronounced effect	Uncommon (contraindicated)
Neurosis	Common	Uncommon	Seldom
Exertion	Usually absent	Always	Equivocal
Valvular lesion	Common	Uncommon	Uncommon
Menstruation	One case	None	None

ventricular failure may be associated with or responsible for such attacks."

Also he stated, "Occasionally attacks of angina pectoris are precipitated by the recumbent position, especially at night, and the patient is forced to walk about or sleep in a sitting position in order to obtain relief. This has been noted particularly in patients with aortic insufficiency and angina pectoris, but I have also observed it in patients with pain due to coronary arteriosclerosis. The term *angina decubitus* has been applied to this type of cardiac pain, which may be precipitated by emotional factors or by increased cardiac output and work associated with recumbency. However, there has been considerable confusion about this term, which has also been applied to the precordial oppression associated with paroxysmal nocturnal dyspnea and the pain accompanying a *cute myocardial infarction*." Treatment was not mentioned.

In his textbook White² stated, "When the

paroxysms come with the patient in bed the angina pectoris is called decubitus, and the prognosis is temporarily grave." He stated further that "In the recumbent position the general blood flow is greater and the heart has more to do than in the upright position, with the patient seated or standing; this fact accounts in part at least for the cases of angina pectoris decubitus. Patients with nocturnal angina pectoris find that by sitting up in bed or in a chair, and especially by standing, the oppression is quickly relieved. A similar but slower relief comes in the case of nocturnal cardiac asthma by a change from the recumbent to the upright position." Treatment was not discussed.

ANGINA DECUBITUS WITH AORTIC INSUFFICIENCY

Boas and Boas³ in their textbook describing angina pectoris with aortic insufficiency, stated the following: "Aortic insufficiency, either rheumatic or syphilitic, may be associated with a distinctive type of anginal attack. The seizure is not induced by exertion, as a rule, and may awaken the patient from sleep. There are sudden palpitations and precordial or substernal

TABLE 2. DIFFERENTIAL DIAGNOSIS BETWEEN ANGINA DECUBITUS OF AORTIC INSUFFICIENCY AND ANGINA DECUBITUS OF CORONARY ARTERY DISEASE

	Aortic Insufficiency	Coronary Disease
Etiology	Rheumatic usually (luectic) possibly	Atherosclerotic
Age	Below age 30	Over age 40
Duration	Markedly prolonged	Moderate
Subjective phenomena	Severe	Moderate or mild
Objective phenomena	Marked	Mild
Blood pressure	Markedly elevated usually	Moderate increase or none
Pulse	Rapid	Equivocal
Nitrites	Often effective (literature)	Never effective
Valvular lesion	Always	Never
Neurosis	Occurs	Common
Emotional lability	More often present	Usually absent
Treatment	To be answered (unknown)	Low-sodium diet Mercurial diuretics
Prognosis	Usually good	Guarded

pain which may radiate down one arm. The pain is intense, but the patient does not remain immobile, instead being restless and perhaps walking around in his effort to find relief. The face is flushed, there may be dilatation of the alae nasi, the heart rate may reach 160, the blood pressure often conspicuously elevated (we have seen it over 300), the respirations are rapid and may reach 30 a minute. Nitroglycerin or amyl nitrite may bring transient relief from pain and lowering of the blood pressure. But the effects are brief and the symptoms usually recur to last

from 30 minutes to several hours. We have never seen an attack terminate fatally unless it was accompanied by severe left ventricular failure." They stated further: "Characteristically this syndrome is encountered in adolescent and young persons. The association of anginal pain, tachycardia, acute hypertension and other vasomotor phenomena suggest that these seizures are reflex 'autonomic storms.'" No specific treatment was recommended.

Levine⁴ stated, "Anginal episodes may come without any precipitating cause while the subject is at rest. They may even wake the patient from sleep; in such instances we try with only partial success to blame the attacks on dreams. A division has been made by some observers between 'angina of effort' and 'angina of rest,' but I see no useful purpose that can be obtained by this distinction. The latter usually follows the former although occasionally the first attack may be of the form described as 'angina at rest.' There are no important practical differences between the two types except that it has seemed to me that those who have had angina and hyperthyroidism are very prone to have attacks at rest." Treatment was not mentioned. (At the present time it appears important and thereby useful to distinguish "angina pectoris of effort" from "angina pectoris of rest" since the prognosis is much different and the treatment if proved acceptable is quite different.)

Vaquez, translated and edited by Laidlaw⁵, presented one of the most complete discussions of angina pectoris and angina decubitus that has been found in the literature. He stated as follows: "Angina pectoris assumes two distinct forms, the first form following exertion, beginning either as retrosternal pain, which is the rule, or by radiating pain, the retrosternal pain coming afterward; and it ceases when the effort is discontinued or a few minutes later. In a second form, the angina breaks out suddenly during rest, especially at night; it becomes intense immediately, the pain, the radiation and the sensation of impending death being at their maximum at the very beginning and the attack may be so violent that death is immediate. If recovery ensues, it is only after a number of hours, during which there are recurrences of the painful symptoms. These symptoms have been called angina pectoris of effort and angina pectoris of decubitus to distinguish the different circumstances of their appearance.

INTERMEDIATE FORMS ARE COMMON

In practice, they are frequently associated and there are also intermediate forms in which features peculiar to each of them are combined or absent.

"Angina pectoris of decubitus. This differs from angina of effort in that the painful seizures occur spontaneously, the influence of effort playing no part. It is called angina pectoris of decu-

bitus because the pain may surprise the patient while in bed, that is, in the most complete repose. It is, in fact, at night that the anginal paroxysms burst forth for the first time, unannounced except for a few special symptoms that we shall describe presently. This type exhibits all the features of angina pectoris. The pain is usually excruciating, of maximum intensity at the start."

It was stated that "the patient sits motionless in bed, is pale and anxious, drops of sweat appear on his face, his pulse is small and rapid and he remains this way for hours awaiting the death which he feels is impending. It is stated that cough follows the pain. Expectoration of frothy mucus streaked with blood and rales in the chest are noted. Objective examination during the paroxysm seldom gives information of importance . . . the pulse is usually increased in frequency contrary to that which happens in angina of effort. It remains full and tense or may be small and threadlike, especially in its severest forms. The arterial blood pressure may be high or low." It was further stated that "the episode may subside spontaneously while under the influence of appropriate treatment, the paroxysms may occur at long intervals until they return with increasing intensity.

"Complete and definitive recovery from angina decubitus is not unusual, but it is only possible in subjects free of organic lesions of the heart or vessels. . . . Angina decubitus appears in any age, either in children, in whom its causes are found to be complex lesions of the heart and extensive adhesions of the pericardium."

Specific treatment was not directed toward the relief of angina pectoris of decubitus.

Schwartz⁶ reported on five individuals with rheumatic heart disease and aortic insufficiency which had in common nocturnal episodes of angina associated with elevation of blood pressure, rapid heart action, flushing of the cheeks, cold perspiration, prolonged duration and lack of effect produced by nitroglycerin and amyl nitrite. There was no fever, no leukocytosis, and no relationship to meals. It was stated the pain may be slightly relieved by effort including change in posture, and that the patient was usually in apparent comfort between the episodes of pain.

SALT AND WATER RETENTION WITH ESTROGENS

For the first time it was mentioned that in females menstruation seemed to influence the episode somewhat, although it was not definitely stated as to whether the episodes were more marked during menstruation, although this might be expected due to the salt and water retaining action of the estrogenic hormone.

White and Mudd⁷ reported eight cases of angina pectoris in young individuals less than 30 years of age all of whom had rheumatic heart disease with one common lesion of aortic insufficiency. This paper contained an excellent

review of the literature concerning angina pectoris in young people with a complete bibliography of the cases found. They assumed that there were definite reports of 42 cases of angina pectoris under the age of 30 to which they added eight of their own, making a total of 50 cases. Many of the episodes were nocturnal in nature and had a longer duration than that of angina pectoris of effort. The authors stated that nitroglycerin usually gave dramatic relief which is somewhat different than many of the previous reports. In one patient it was stated that the episodes were increased at night and followed dreams usually. It was further stated that the relationship between angina pectoris and luetic aortitis with or without aortic regurgitation was too well known to demand more than passing mention. It was their impression that exertion was less significant on bringing on attacks of pain than was usually noted in angina pectoris of effort; that the attacks were very apt to come on with the patient quiet and even in bed although excitement did favor their occurrence.

Stolkind⁸ in his paper stated that the attack may come on during the day even in a patient who had been in bed for weeks as well as at night during sleep. He mentioned that Vaquez and other French authors distinguished, in his opinion, unnecessarily, between angina following effort and angina of rest, decubitus. He mentioned the case of Heberden in 1802, the first case of angina pectoris in a 12 year old boy. The information available did not reveal whether or not the patient had rheumatic heart disease or nocturnal episodes of pain. He reported papers by Stewart in 1906, Heubner in 1906, and Bramwell in 1915, all cases appearing to be rheumatic heart disease with aortic insufficiency and nocturnal episodes of substernal pain (angina decubitus).

Keefer and Resnik⁹ reported that on occasion pain of true angina pectoris may arise spontaneously during sleep; that is to say, without provocation of one of the usual stimuli: muscular effort, cold, emotional and/or a hearty meal. But these exceptions are even more apparent than real in many cases. He again summarized the observation that there is an increase on demand of the heart such as might occur during sleep when in the presence of dreams. In their opinion it is a matter of experience that nocturnal attacks, even when they are not caused by coronary occlusion, are often of rather long duration.

Lewis¹⁰ discussed four patients with angina pectoris in which the episodes were frequently nocturnal in nature, and in his opinion accompanied by a pronounced rise in pulse rate and increase in blood pressure. He stated that amyl nitrite gave some relief although he did not believe that this was due to a lowering of the blood pressure. In one case flushing was usual and respirations were reported to be rapid. It

was not stated as to whether or not all the patients suffered from rheumatic heart disease with aortic insufficiency.

ANGINA DECUBITUS WITHOUT AORTIC VALVULAR DISEASE

Lewis did state that most of the cases were male individuals who had free regurgitation although he apparently admitted the characteristic syndrome in one middle aged man in whom no sign of aortic valvular lesion could be found. He described the pain and characteristic findings to be very similar to that of angina pectoris of effort, the episodes particularly prone to happen in the early hours of the morning, awakening the patient from sleep. The duration appeared to be prolonged. Pallor was not a feature of the attacks; on the contrary, the face may be flushed with a deep suffusion. He stated that a distinctive feature was a conspicuous change in the heart rate and blood pressure, both rising to high points. Rapid respirations were the rule and a special feature to be noted. He stated that it was well known that amyl nitrite was of particular value in stopping the pain of angina decubitus.

Eakin¹¹ reported a case of a 14 year old girl in which there was severe precordial pain, pains radiating down the left arm, the episodes frequently occurring at night. He noted no change in blood pressure during or following the attacks. He stated that they were immediately relieved by nitroglycerin or amyl nitrite. Apparently this patient would, for the most part, awaken from sleep and cry out with severe constricting pain in the precordium, always radiating to the left arm. Less frequently episodes were observed during the day, although later when she was ambulatory they would come on with exertion.

Bland and White¹² reported in their paper a special group of young people with rheumatic heart disease and disabling angina pectoris who apparently received striking benefits following sympathetic nerve block. These patients apparently had advanced rheumatic heart disease with a common lesion of free aortic regurgitation and the term angina decubitus was used in all cases. These episodes were most severe at night. Pulse rate and blood pressure were always increased. There was no shortness of breath until later in the course of the disease. Flushing of the skin and profuse perspiration were noted. Nitroglycerin gave relief in mild attacks, but in severe attacks morphine sulfate was usually required. Pronounced benefit obtained by sympathetic nerve block was claimed by these authors. Autopsy examination revealed the coronary arteries to be widely patent throughout.

DIFFERENTIATION RECOMMENDED

Riseman and Brown¹³ reported a series of cases of angina pectoris and recommended the use of such terms as "angina on exertion," "angina on emotion," and "angina during rest

or during sleep." It was stated that angina pectoris when secondary to valvular heart disease, aortitis, paroxysmal arrhythmia (anemia), or thyrotoxicosis was quite similar to that of coronary artery disease but the attacks were more likely to be prolonged and frequently occurred without obvious precipitating cause.

Ernstene and Schneider¹⁴ reported on angina pectoris in young individuals with aortic insufficiency as follows: The most important distinguishing characteristic finding consisted of the occurrence of nocturnal seizures, and it was these attacks that usually constituted the principal complaint of the patient. They stated that the nocturnal attacks were usually extremely severe, lasting 10 to 20 minutes, and frequently occurring several times during the night. It was stated that nitroglycerin usually gave prompt relief, but patients who had no treatment often reported that the only spontaneously beneficial measure consisted of getting up and walking about.

These episodes were further distinguished by a common occurrence of a prominent vasomotor change, such as flushing of the face, sweating, palpitation and throbbing of the vessels of the neck. Ernstene and Schneider noted that in the numerous references cited that the syndrome was apparently uncommon, the total number of cases reported being well under a hundred. They stated that although amyl nitrite and nitroglycerin usually afforded prompt relief from the seizures of angina decubitus there were no medical measures which were effective in preventing the development of these episodes.

Boas¹⁵ reported a case of angina pectoris in a 19 year old girl with rheumatic heart disease and aortic insufficiency. This patient was described as being very neurotic and the slightest emotion or excitement upset her markedly. It was noted that the pulse rate was increased and the systolic blood pressure rose to 250 to 300 millimeters of mercury. These episodes were associated with rapid respirations and the face became markedly flushed. There was no evidence of pulmonary congestion. Nitroglycerin was given resulting in a drop in blood pressure and partial relief apparently from the episode followed by a recurrence or a renewal of the episode.

Soloff¹⁶ in a more recent paper stated that angina pectoris of decubitus in his patients was usually of longer duration than angina pectoris of exertion. The three patients usually had a flushed, warm skin with perspiration in contrast to the pallid, shock-like state seen in individuals suffering from angina pectoris of effort. The possibility of these patients being considered "neurotic" was mentioned.

LOW SODIUM DIET AND MERCURIAL DIURETICS USED

He was the first to mention that angina decubitus is abolished by low sodium diet and

by the use of mercurial diuretics, "a manifestation of latent edema that pools into the lungs and responds to diuretics as rapidly as did the more common symptoms of dyspnea, cough and insomnia."

Paul¹⁷ presented five individuals suffering from angina decubitus, all apparently on an arteriosclerotic basis with a possible exception of one patient who had a blood pressure of 180 systolic over 80 diastolic, and a Grade II, harsh, systolic aortic murmur. Electrocardiographic tracing showed characteristic evidence of myocardial infarction in two individuals and suggestive evidence in a third. None of the patients presented evidence of congestive heart failure. He is the second author to suggest the use of mercurial diuretics in angina decubitus although the use of a low sodium diet was mentioned, apparently it was not used in conjunction with the mercurial diuretics.

Proger¹⁸ in the *Modern Concepts of Cardiovascular Disease*, May, 1951, mentioned angina decubitus in his discussion of both acute and chronic coronary artery disease as follows: "One form of acute coronary disease deserves particular mention, namely, angina decubitus. There are certain clinical merits to the designation of angina decubitus as acute coronary disease for at least several weeks after its onset. In the first place, it indicates that one is dealing with a period of transition. Secondly, it keeps one on the alert for eminent and serious complications. Thirdly, it makes one aware of the real possibilities of more or less spontaneous improvement; the knowledge that in time great improvement may occur spontaneously is a source of hope which is of great help to the physician and to his patient in that trying period of almost complete invalidism. It is a failure to recognize a frequency of spontaneous and considerable improvement in acute coronary disease with angina decubitus which has occasionally led to misinterpretation of striking methods resulting from various therapeutic efforts." With this we certainly agree.

It has already been mentioned that the etiology of angina decubitus may rest in the greater work imposed upon the heart while in the recumbent position, disturbed sleep, including dreams, modified by reflex changes including extensive rise in blood pressure, increased heart action, change in respiration and other circulatory changes such as encountered in paroxysmal nocturnal dyspnea. The reflex discharge of epinephrine into the circulation under emotional disturbances during these episodes was discussed by MacWilliam.¹⁹ Also, if a discharge of epinephrine is to be considered strongly, undoubtedly ACTH and Cortisone with their accompanying salt and water retention activities might be considered as arising under periods of stress and strain according to the theory of

Selye²⁰, and has been described previously as "alarm reaction," and the "adaptation syndrome."

CONCLUSIONS

(1) Angina decubitus is a characteristic, recognizable syndrome of clinical importance which occurs in the presence of coronary artery disease as well as in the presence of aortic valvular disease (aortic insufficiency).

(2) The response to a low sodium diet and/or mercurial diuretics is gratifying and is therefore recommended in the treatment of angina decubitus.

(3) The etiology may be on the basis of salt and water retention accompanying subclinical congestive heart failure with diminished cardiac output, markedly diminished renal function, and subsequent salt and water retention. The possibility of pituitary and adrenal cortical participation is considered.

(4) Exchange resins, diamox® (acetazoleamide-Lederle) were not used in the treatment of these patients but it would appear likely that they might be of value in the further elimination of sodium and water from the body.

(5) Heparin was used in one patient, the effect of which could not be determined.

(6) Finally, we would like to reiterate that one must never forget the guarded prognosis in these patients, at least, during the period of transition and furthermore, the unquestionable spontaneous improvement that may occur no matter how they are treated.

(7) We have not seen angina decubitus with aortic insufficiency and therefore we can only suggest that the low sodium diet, mercurial diuretics, exchange resins and acetazoleamide be given a therapeutic trial.

Acknowledgment. The author wishes to express his appreciation to Miss Virginia E. Bowers, R.N., for her assistance in the preparation of this paper and to Mrs. Mabel Hindman, secretary, for the typing of the manuscript.

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The Story Behind the Word

Some Interesting Origins of Medical Terms

Palate—Coming from the Latin word "palatum" and designating the roof of the mouth, this term is of doubtful origin. It may be derived from or related to the Latin words "pabular or pascere" both of which mean to feed. The hard and soft palates were described by the sixteenth century Italian anatomist Fallopius.

Yaws—Yaws, or frambesia, is a specific contagious disease prevalent among primitive people in the tropics, resembling syphilis in its course and characterized by striking cutaneous lesions. It is named for the raspberry-like appearance of the eruption and the term "yaws" is said to be an African dialect term for "raspberry." The original home of yaws was among the natives of Africa and it was spread to different parts of the world by the slave trade. The causative organism, *Treponema pertenue* was discovered in 1905 by Castellani and closely resembles the *Treponema pallidum* of syphilis. Like syphilis, yaws also causes a positive Wassermann reaction and responds to treatment by anti-syphilitic drugs.

Brandy—This is short for brandywine which in turn comes from the Dutch word "brandewijn," or burnt wine. However, the Dutch word "branden" meant to distill as well as to burn. The shortened form "brandy" came into use in about the seventeenth century.

Beer—The name of this common intoxicating beverage which is made from malt or prepared barley is derived from the Anglo-Saxon word "beor." This in turn stems from the common Teutonic Root "bere," or barley. From this root also springs the German word for beer which is "bier."

Whisky—Literally meaning the "water of life" and comparable to the Latin "aquae vitae." The modern word whisky is derived from a contraction of the Old English spelling "whiskybea," which in turn comes from the Gaelic term "uisge-beatha." The Gaelic "uisge" meaning water and "beatha," meaning life.

—HARRY WAIN, M. D., Mansfield, Ohio.

Obstruction of the Respiratory Passages*

JOHN STORER, M. D.

MAINTENANCE of a clear airway is of prime importance in good patient care. One should include, in the examination of each patient, an evaluation of the patency of the respiratory passages. Awareness of this facet of the clinical picture must be carried out at all levels of treatment. The emergency room physician, anesthesiologist, internist, obstetrician and surgeon, to list a few, must be eternally vigilant in keeping the respiratory passages clear.

When partial or complete airway obstruction has been recognized, a rapid set of circumstances should be effected to produce a return of the free air passage. This requires a knowledge of the methods available and familiarity with the technical nature of each method. The measures available for tracheobronchial catharsis are:

1. Bronchoscopic aspiration
2. Catheter aspiration
3. Tracheotomy

Prophylactic measures are, of course, helpful in precluding the development of a respiratory obstruction. Routine deep breathing and coughing following surgical procedures is of aid in minimizing the problem of tracheobronchial secretions. Control of chest pain with intercostal blocks and opiates will often assist the patient to effect a productive cough. Judicious use of expectorants, bronchodilators and many other agents are of help in certain instances.

It should be emphasized, however, that most respiratory obstructions are mechanical problems and are best treated by mechanical methods, i. e., direct removal of the obstructive element. How futile it is to treat an atelectatic lobe with a carbon dioxide cone when the bronchus is obstructed by aspirated food! Of similar futility is the treatment of the asthmatic with bronchodilators when his tracheobronchial tree is filled to the very brim with mucous. In either of the foregoing instances a rapid aspiration bronchoscopy is more effective than the entire pharmacopeia administered via the parenteral route.

The problem presented in many patients with retained tracheobronchial secretions may be handled by catheter aspiration. The technical details of this procedure should be familiar to every physician. Numerous esophagi have been aspirated in the name of the tracheobronchial tree. Such aspiration unfortunately does not improve the patency of the airway.

It is our custom to carry out this method with the patient in the sitting position, with jaw protruding and tongue extended. The catheter

The Author

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is passed through the nose into the posterior pharynx and while the patient coughs or inspires, it is thrust through the open glottis into the trachea. Inability of the patient to phonate and the characteristic cough which ensues is ample proof that the catheter has reached the tracheobronchial tree.

INDICATIONS FOR TRACHEOSTOMY

In spite of the efficacy of bronchoscopy and catheter aspiration in certain cases, there are other instances when tracheostomy is specifically indicated. The general indications for tracheostomy are:

1. Obstruction of pharynx or larynx;
2. Tracheobronchial secretions—of such nature that they cannot be controlled by catheter or bronchoscope;
3. Traumatic wounds of neck;
4. Prophylaxis.

In this institution we have increased the indications for tracheostomy. We feel that a "wait and watch" policy in the semi-obstructed patient is a direct invitation to catastrophe. Complete obstruction, anoxia and death can occur too rapidly to countenance temporizing measures.

Prophylactically, tracheostomy is done on all patients subjected to sternum splitting incisions and extensive neck dissections. In the former instance it is so difficult for the patient to cough effectively that we advocate tracheostomy routinely. Edema and extravasations of blood following extensive neck surgery may compromise the air passages. It is wise under these circumstances to follow the definitive surgical attack with a tracheostomy.

Retained tracheobronchial secretions are encountered frequently. In addition to the primary illness, there may be an associated weakness or muscle spasm which renders the plosive force inadequate. Under certain circumstances the secretions are of such nature that they cannot be adequately relieved by catheter or bronchoscopic aspiration. Some of these situations for which we have recently performed tracheostomy are pulmonary edema, tetanus, measles encephalitis, postaplectic states and the like.

Obstruction of the pharynx or larynx is seen in

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Submitted June 27, 1955.

inflammatory lesions of those sites. Acute tonsillitis may be so severe as to completely occlude the airway. Vocal cord paralysis, acute laryngeal trauma and allergic laryngeal edema may likewise be responsible for complete obstruction.

ACUTE LESIONS IN CHILDREN

Our most frequent experience among this group has been in the young child with acute laryngotracheobronchitis. These children characteristically develop marked obstruction in a precipitous fashion. Upon arrival of such a patient to this institution an anesthesiologist is in constant attendance, with laryngoscope and endotracheal tube, until tracheostomy has been safely done.

After general anesthesia and endotracheal intubation, a leisurely operative procedure may be done. We prefer the technique of Jackson. The skin is grasped with a hook at the level of the cricoid cartilage. A midline incision is made down to the suprasternal notch. The incision is continued in the midline, separating the ribbon muscles and incising the pretracheal fascia. All bleeders are carefully clamped and tied.

The trachea is grasped and elevated with a hook and two cartilaginous rings incised in a cephalad direction. This will avoid injury to the venous tributaries at the base of the wound. After the trachea has been incised, the opening is dilated and a tracheotomy tube inserted. It is important to close the wound loosely with skin sutures above and below the tracheostomy. Such wounds are easily closed when the tube has been removed permanently.

Cleanliness is maintained in the after care of the tracheostomy patient. The inner cannula is removed and cleaned every four hours unless necessary oftener. A catheter attached to a glass Y tube is used for aspiration. The catheter is kept in aqueous zephiran® (1-1000) when not in use. Prior to aspiration it is rinsed in sterile saline.

With the patient's chin to the right, the tracheotomy tube is rotated in a counter clockwise direction. The catheter is thus directed toward the left main stem bronchus. When it has been passed as far as possible the patent limb of the glass Y tube is closed, effecting suction, and the catheter slowly removed. With the head and tube turned in the opposite direction the right main stem bronchus is similarly aspirated. The interposition of a glass Y insures that large amounts of oxygen are not removed over a dangerously long time.

After 48 hours the tracheotomy tube is changed and this followed every other day. Oxygen may be given by catheter into the tube. Excessive oxygen is drying to the tracheobronchial tree and should not be used unnecessarily. When there is no obstructive element present the tracheotomy tube may be plugged at all times except during aspiration. After permanent removal of the tube the skin edges are approxi-

mated with flamed adhesive. In a few days the skin edges are usually well healed. No instance of wound revision has been necessary when the foregoing procedure has been followed.

THE DIRE EMERGENCY

Occasionally one is confronted with a situation where tracheostomy must be carried out with *extreme rapidity* under adverse circumstances. It is best to incise the cricothyroid membrane and with a twist of the knife blade an airway can be established immediately. Some physicians carry a No. 12 gauge needle for this purpose. This may be thrust quickly into the cricothyroid membrane and enough oxygen interchange established to maintain life.

The Increasing Awareness of Thyroid Carcinoma Today

A cursory review of the relevant medical literature of the past 10 years leaves one with the impression that physicians have become increasingly concerned with thyroid carcinoma. Quite possibly, of course, the growth in incidence is more apparent than real. An increasing awareness of this lesion, on the part of physicians, has resulted in a heightened level of suspicion, which, in turn, has led to more diagnoses. Then too, diagnosis is more frequently followed by referral than in earlier years. Cases which previously would have been judged too far advanced for treatment are now being sent to clinics where radioactive iodine is available for diagnosis and treatment. In the seven years since the establishment of the radioisotope laboratory at the State University of Iowa, as many new cases have been examined there as were seen at University Hospitals during the preceding 20 years.

Whether, in addition to these factors causing an apparent growth in incidence, there is in fact a real increase cannot be determined on the basis of the information presently available. Winship's studies indicate its prevalence in children, and indeed it has recently been observed that carcinoma of the thyroid is one of the commoner neoplasms found during childhood.

With the use of radio-iodine, refinements in surgical technic which have made excisional procedures more feasible, and with our steadily expanding knowledge of the behavior of the lesion, management has become more complicated. More importantly, the institution of proper therapy enables us to achieve improved results.

Five-year survival rates have been reported as low as 20 per cent and as high as 80 per cent. Of 77 patients with thyroid carcinoma in whom the diagnosis was established more than five years ago, 38 (just less than 50 per cent) have survived for five or more years, four of them currently being alive with neoplasm.—Joseph A. Buckwalter, M. D., Iowa City: *J. Iowa M. Soc.*, 46:187, April, 1956.

A Comparative Study of Neo-Silvol® and Terramycin® As Prophylactic Treatments in the Eyes Of the Newborn*

KENNETH J. CHAPMAN, JR., M. D.

PHYSICIANS delivering and caring for newborn infants are aware that ophthalmia neonatorum is seen infrequently since the introduction of the Credé method of eye treatment in the newborn. We still see, however, a great many reactions in the newborn's eyes that should be eliminated. These reactions have been attributed to the silver preparations still in use in our hospitals. In 1953, thirty-two states required the use of 1 per cent silver nitrate and the rest required some allied solution. The 1954 *Ohio Public Health Manual* states that some prophylactic agent must be used, but the agent is not defined.

Mann ran a large series in Australia using 1 per cent silver nitrate, and saline swabbings alone in the control group, and came to the conclusion and suggested that the use of silver nitrate is unnecessary in a modern hospital and in a population in which gonorrhea is rare. In a study where silver nitrate and terramycin® ophthalmic ointment were used, Willcockson states that the nursery personnel could soon distinguish between the two drugs as to the effects on the babies eyes; that is, those that received the terramycin® had fewer reactions. He feels it is a safe and proper replacement therapy in routine prophylaxis in newborn's eyes. Dieckmann stated that from 1931 to 1953 there were no cases of gonorrheal ophthalmia at the Chicago Lying-In Hospital.

METHOD

For the past several years a 10 per cent solution of neo-silvol® has been used in our hospital. For this study it was elected to use an ophthalmic solution of terramycin®. The solutions of 10 per cent neo-silvol® and terramycin® were prepared by adding sterile distilled water to the dry powders. The drugs were never used if more than 48 hours old.

All deliveries occurring in the delivery room

*This study was conducted in the newborn nurseries of the White Cross Hospital, Columbus, Ohio. Permission for the study was granted by the Ohio Department of Health. The oxytetracycline hydrochloride was furnished by Chas. Pfizer and Co., Inc.

Submitted February 9, 1956.

The Author

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designated as No. 1 received the silver preparation and all occurring in room No. 2 received the terramycin® solution. Two drops of either of the solutions were added to each eye. A record was kept as to the type of treatment each babe received. No further treatment was added to the foregoing regime unless specied by the attending physician. If this happened, the case was deleted from the series.

The babies' eyes were examined daily and the reactions graded as follows:

- Class 1. Edema of the lids without discharge.
- Class 2. Edema of the lids with a clear discharge.
- Class 3. Edema of the lids with a purulent discharge.

All examinations were done by a single resident so that there would be as little discrepancy as possible in the results obtained. In grading the reactions it must be noted that the amount of edema seen was highly relative, and this again is why one resident did the examinations. In all cases developing a reaction a smear and culture were made.

RESULTS

This series covers 2,000 live births occurring between July 1, 1954, and April 1, 1955. One thousand babies are included in each group. Referring to table 1, it can be seen that the neo-silvol® group gave the largest total number of reactions. The highest number of reactions in both groups occurred in the category designated as Class 2. However, it was not this group that gave the positive cultures, rather the group designated Class 3. This led us to believe that

TABLE 1

	Reactions		Smears & Cultures Done		Positive Cultures	
	Neo-Silvol	Terramycin	Neo-Silvol	Terramycin	Neo-Silvol	Terramycin
Class 1	27	15	27	15	0	0
Class 2	103	23	103	23	0	0
Class 3	21	4	21	4	5	1

Classes 1 and 2 reactions were therefore chemical or irritative ones in nature. The five organisms cultured from the neo-silvol® group were:

<i>Anaerobic Streptococci</i>	3
<i>Klebsiella pneumoniae</i>	1
<i>B. subtilis</i>	1

The one positive culture from the terramycin® group was *Pseudomonas aeruginosa*. It is interesting to note that bacteria were seen on several of the slides even though no growth was obtained on culture. These totals were not kept. No intracellular diplococci were seen on any of the smears.

SUMMARY AND CONCLUSION

A series of 2,000 live births, using a silver preparation and terramycin® as a routine prophylactic therapy in the newborn's eyes has been reviewed. Results from this study show that the large number of chemical reactions attributed to the silver solution can be decreased by the use of an ophthalmic terramycin® solution. It is also shown that terramycin® protects the eyes from pathogenic organisms as well as or better than the silver solution, and that it would not only be a safe but a more desirable replacement therapy in the routine treatment of eyes in the newborn babe.

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Gamma Globulin in Treatment of Infectious Hepatitis

Numerous articles have appeared in the past several years concerning the use of gamma globulin prophylactically in the prevention of infectious hepatitis in exposed individuals. Drake and Ming made a careful comparison of two dosage levels in the use of gamma globulin in exposed inmates in a closed institution. Stokes delved into the length of protection afforded by immune serum globulin. But nowhere in the literature is there any reference to the use of gamma globulin as a direct treatment for infectious hepatitis in a patient actively ill with this disease and in the acute and icteric phase. . . .

A series of 42 cases of infectious hepatitis were treated during the past 8 months with 6 cc. gamma globulin injected intramuscularly as soon as the diagnosis was made clinically. Thirty-nine responded very rapidly and effectively with an apparently complete cure in 7 days. Two children required a repeat injection one week after the first.

The question is raised: Would not gamma globulin similarly be effective in the active treatment of other viral infections?—Fred J. Ansfield, M. D., Glidden, Wis.: *Wisconsin M. J.*, 55:431, April, 1956.

KEEPING UP WITH MEDICINE

• THE PRESIDENT of the American Academy of Orthopedic Surgeons urges the return of the cane to the well dressed man's outfit, the reason being that if the cane were once again held in high regard then it would be acceptable to persons with slight physical infirmities. He points out that the force thrown on the hip in walking can be greatly reduced by the use of the cane with a strong push downward on the opposite side.

* * *

• THE SURVEY in the state of Washington showed that the two most frequent reasons for people seeing a physician were colds—influenza, bronchitis and pneumonia; and then accidents.

* * *

• BROWN of Duke University has designed an inexpensive, throw-away series of plastic bags to be used as an artificial lung which bids fair to eliminate time as a major factor in future surgery of the heart.

* * *

• THERE NOW have been 18 studies that implicate tobacco smoking as a cause of lung cancer. Some 20,000 Americans are now dying each year from lung cancer. If smoking were eliminated some 80 per cent of these deaths would be eliminated.

* * *

• THE NATIONAL Bureau of Standards has perfected an x-ray machine that takes a single, panoramic picture of the entire dental arch on a 5 by 10 inch film.

* * *

• THE THEORY behind the new pills from Germany said to be helpful to the diabetic seems to be that the drug blocks the enzyme *insulinase* which is believed to be in excess and so in turn is able to block all or nearly all of the insulin manufactured by the diabetic. This new sulfonamide seems to block the insulinase and thus allows the insulin to do its work.

* * *

• ONE-HALF of the patients admitted to general hospitals today will get an antibiotic at some time during their stay.

* * *

• IT MAY be possible that some disorders diagnosed as neuro-allergy are in fact manifestations of galactosemia.

* * *

• MANY A SEVERE reaction to penicillin may be prevented by inquiring whether the patient has had the drug before and, if so, was there any reaction; is he an allergic individual and does he come from allergic family; by skin testing with a scratch test with 1-1,000 dilution of the antibiotic; by giving sufficiently large dose to achieve the desired result promptly; by discontinuing the drug as soon as the result is accomplished.—J. F.

Diagnostic Problems in Uveitis

ARTHUR M. CULLER, M.D., TORRENCE A. MAKLEY, M.D.,
JAMES W. LONG, M.D., and TED SUIE, Ph.D.

UVEITIS may be defined as an inflammation of the uveal tract which comprises the iris, ciliary body and choroid. Some of the cases of uveitis such as those due to metabolic disturbances, degenerations or acute febrile illnesses are reasonably understood and self-explanatory. However, the majority of cases fall into the endogenous, non-purulent, often recurrent type. This group, which offers the greatest challenge in arriving at an etiologic diagnosis, comprises the material to be presented in this paper.

Toward the end of the last century most cases of uveitis were thought to be of a syphilitic or tuberculous nature. Undoubtedly, many of them were. However, at the present time, with more adequate control methods for both of these diseases, they cannot be incriminated as often. At the beginning of this century, the idea of a focus of infection as a causative factor in uveitis was considered by many. Even today this theory is respected. Every ophthalmologist has experienced a case of uveitis which regressed dramatically when a focus of infection was eliminated. The most common of these foci are found in the teeth, tonsils, nasal sinuses, prostate, deep urethra, colon, urinary tract and gallbladder. Although it is generally agreed that organisms and/or their products from a focus of infection may precipitate a uveitis, the mechanism is not clear.

Woods¹ prefers to classify uveitis into two large groups—the granulomatous and non-granulomatous types. The former is believed to be due to a direct infection of the uvea by such organisms as *Mycobacterium tuberculosis*, *Treponema pallidum*, *Brucella* sp. and certain mycotic agents. If the tissues acquire a hypersensitivity to these organisms subsequent contact with the homologous antigen would result in ocular inflammation. This group is characterized by a slowly progressive, rather torpid but relentless course. On the other hand, the non-granulomatous type is believed to be due to a sterile allergic reaction caused by such organisms as streptococci and gonococci. The clinical picture is that of a fulminating inflammation and congestion is marked. Most often the anterior segment is involved.

There are also more complicated cases in which an original granulomatous uveitis has had superimposed upon it a non-granulomatous type of reaction.

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The ideal treatment would be to find and eliminate the causative agent and to desensitize the patient to it while building up his immunity against it. In order that our treatment shall be as rational as possible each patient with active uveitis is subjected to an intensive survey in an attempt to learn the part played by each of the two major factors, infection and allergy. Since 1950 we have used as a guide Alan C. Woods' diagnostic survey of uveitis² which "directs the investigation of possible causes of the disease into the most necessary and fruitful fields." (See Page 595 for survey form.)

In addition to doing a pertinent history, blood and skin tests, we refer the patient to the department of radiology for roentgenograms of the chest and sinuses, and to the dentist and ear, nose and throat specialist to rule out foci in these areas. The internist can often help us in this search and is frequently needed for advice as to the safety or danger of large doses of cortisone or typhoid vaccine. Referral to the genitourinary man or gynecologist is sometimes indicated. Since it is impossible to explore all the known allergens, skin testing is limited to those which have been most often incriminated both clinically and experimentally. If organisms can be recovered from a focus of infection, the patient is skin tested with the autogenous vaccine and if sensitive, desensitization is attempted. Thus a definite or presumptive diagnosis is possible in many cases and can be followed by specific therapy. This is much more effective in the treatment of the current attack and the prevention of future recurrences.

The alternate approach is treatment with often

Submitted August 10, 1955.

less effective nonspecific and symptomatic measures; along this path there is a much higher probability of future devastating recurrences, even if the current attack is quieted.

Approximately 150 patients have been surveyed by the described diagnostic method. However, cases of scleritis and keratitis (which present similar problems) and those cases which could not be followed adequately have been eliminated. Since the number of cases remaining is relatively small, the results should be considered of a preliminary nature.

Table 1 demonstrates that the incidence of foci of infection in patients with non-granulomatous uveitis is much higher than in the granulomatous group. These results compare favorably with those obtained by Woods.² In patients having the granulomatous type there was a greater evidence of systemic granulomatous disease than in the non-granulomatous group (table 2). On the other hand, the incidence of specific bacterial hypersensitivity to streptococci and autogenous organisms was greater in the latter, as may be seen in table 3. This is an important finding and it confirms the results of Woods which demonstrated that a high percentage of patients with non-granulomatous uveitis were sensitive to streptococci. The results of the therapy, specific, nonspecific, and combined are presented in table 4.

TABLE 1. INCIDENCE OF FOCI OF INFECTION IN PATIENTS WITH NON-GRANULOMATOUS AND GRANULOMATOUS UVEITIS

Types of Uveitis	Number of Patients	Incidence of Infection
WOODS		
Non-Granulomatous	101	55%
Granulomatous	107	28%
O.S.U.*		
Non-Granulomatous	27	59.2%
Granulomatous	43	11.1%

The results compare favorably with Woods' whose larger group also showed a greater incidence in the non-granulomatous group.

*Ohio State University.

TABLE 4. RESULT OF THERAPY

Response	Non-specific	Specific	Nonspecific & Specific	Total
Poor	9	3	6	18 (31%)
Fair	5	1	2	8 (13%)
Good	12	9	12	33 (56%)

Specific therapy includes:	Non-Specific therapy includes:
1. Streptomycin & PAS for T. B.	1. Typhoid
2. Specific vaccine (desensitization)	2. Atropine
3. Elimination of focus of infection	3. Salicylates
	4. Rest
	5. Antibiotics (except Streptomycin)
	6. Cortisone & ACTH

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TABLE 2. EVIDENCE OF GRANULOMATOUS DISEASE IN PATIENTS WITH GRANULOMATOUS AND NON-GRANULOMATOUS UVEITIS

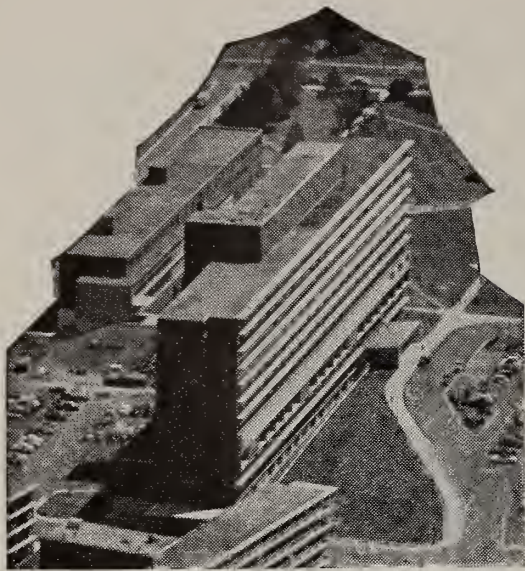
Types of Uveitis	Evidence of Systemic Granulomatous Disease					Total Incidence	
	Tuberculosis	Brucellosis	Boeck Sarcoid	Syphilis	Others	Positive	Negative
WOODS							
Granulomatous 107 patients	50	14	6	5	8	83 (78.5%)	24 (22.5%)
Non-Granulomatous 101 patients	9	1	0	0	0	10 (9.8%)	92 (90.2%)
O.S.U.							
Granulomatous 43 patients	25	1	1	0	2	29 (67.4%)	14 (32.6%)
Non-Granulomatous 27 patients	6	0	0	0	0	6 (22.2%)	19 (77.8%)

It is evident that patients demonstrating extraocular granulomatous diseases also demonstrate a much higher incidence of the granulomatous type of uveitis.

TABLE 3. INCIDENCE OF BACTERIAL HYPERSENSITIVITY IN PATIENTS WITH NON-GRANULOMATOUS AND GRANULOMATOUS UVEITIS

Types of Uveitis	Number of Patients	Specific Bacterial Hypersensitivity			Total Positive reactions in %
		Stock Streptococcus Vaccines	Autogenous Vaccines	Other Organisms	
WOODS					
Non-Granulomatous	101	73	15	2	89%
Granulomatous	107	21	0	0	20%
O.S.U.					
Non-Granulomatous	27	15	3	3	77.7%
Granulomatous	43	17	0	1	39.7%

With three exceptions the skin reactivities were entirely due to various strains of streptococci. Woods' results also demonstrate that the bacterial sensitivity was almost exclusively limited to strains of streptococci.



A Case Record

From The University Hospital,
Columbus, Ohio

Edited Under the Auspices of the Ohio Society of Pathologists

Philip Wasserman, M. D., President

Presented by B. K. Wiseman, M. D., and Emmerich von Haam, M. D.

Edited by Dr. von Haam

PRESENTATION OF CASE

A SIXTY-TWO year old colored female was admitted with the chief complaint of pain in the chest of approximately six weeks' duration. The pain would apparently disappear in 15 minutes if the patient rested. She was unable to characterize the pain. The episodes of pain occurred usually during the morning hours and were associated with a nonproductive cough and occasional emesis. She also developed slight shortness of breath but there was no orthopnea, cyanosis or peripheral edema. In the last six weeks she had lost 30 pounds in weight, but she had no diarrhea, constipation or change in bowel habits. The history indicated that six years ago she had a similar episode of rapid loss of 20 pounds of body weight.

In addition to her chest pain she related an unreliable history of abdominal pain which had troubled her periodically for over 20 years. This pain also had been noticed for the past six weeks and apparently was associated with weight loss. The pain was described as being located in the right lower quadrant and right flank, was intermittent, sharp and lasted 1 to 2 minutes. It occurred mainly at night. At one time she described it as originating in the right flank and radiating to the left flank at the level of the umbilicus.

These pains had occasionally been associated with a small amount of emesis. They were unrelated to bowel movements, to dietary intake or to position. The patient denied hematuria or melena. She stated that she had been hospitalized previously for similar complaints. The history, as obtained from the patient, seemed somewhat unreliable due to her confused state.

PHYSICAL EXAMINATION

The patient appeared to be slightly lethargic, quite slow to comprehend and quite confused. The

blood pressure was 154/110, temperature 100°F., pulse 70 per minute and respirations 30 per minute. The breath had a fetid odor. The pharynx was not injected. Superficial lymph nodes were not palpable.

Auscultation and percussion of the chest revealed diminished breath sounds over both lung bases with some associated crackling rales. The heart was enlarged to the anterior axillary line. There was a harsh systolic and diastolic murmur in the left lateral area over the apex and along the left sternal border. There were systolic and diastolic murmurs in the aortic area. There were occasional extrasystoles.

A soft, freely movable, nontender mass measuring 15 by 6 by 4 cm. was palpable in the left lower abdominal quadrant extending superiorly from the inguinal ligament. The liver was palpated on deep inspiration. There was no tenderness or other masses in the abdominal cavity. The vaginal examination revealed some vaginal stenosis. The neurological examination revealed normal deep tendon reflexes. Sensation was intact. The cranial nerves seemed normal.

LABORATORY DATA

The admission white blood count was 6,950 with 62 per cent neutrophils, 34 per cent lymphocytes, 2 per cent eosinophils and 2 per cent monocytes; the red blood count was 3.4 million and the hemoglobin 10 Gm. Urinalysis revealed a specific gravity of 1.020, protein 5 mg., and occasional red blood cells and a few bacteria in the sediment. The blood sugar, blood urea nitrogen, van den Bergh and blood cholesterol were within normal limits. The serum proteins were 8.4 Gm. with 3.7 Gm. albumin and 4.7 Gm. globulin.

The thymol turbidity was 30 units and the cephalin flocculation was 2 plus. The blood serology was negative for syphilis. Serum agglutination tests for typhoid, paratyphoid and brucella were negative. The glucose tolerance

Submitted March 21, 1956.

test showed a rise of the blood sugar to 245 mg. in 2 hours and 233 mg. in 3 hours, which was interpreted as a possible diabetic curve. The spinal fluid examination revealed data within normal limits. A blood culture taken on the day prior to demise was positive for alpha streptococcus.

The electrocardiogram was interpreted as "abnormal due to diffuse slowing" and was suggestive of left ventricular enlargement.

ROENTGENOGRAPHIC EXAMINATION

A chest film revealed a pneumonic process or an infarct in the left base. The heart was about 20 per cent enlarged. The excretory urograms, the upper gastrointestinal series, and a barium enema revealed essentially normal findings except for the presence of impacted fecal masses in the lower sigmoid. The gallbladder was visualized only after a reinforced dose of dye.

HOSPITAL COURSE

The patient continued in her lethargic state during her eight days in the hospital and had no specific complaints. She had a temperature of 100°F. on admission, remained afebrile during the second hospital day, spiked twice to 100°F. on the third day and again remained afebrile for the following two consecutive days. She then began to show daily spiking temperatures ranging from 100 to 103°F. Her pulse varied between 70 and 100 per minute. During her hospital stay she received seconal® and castor oil, and on the day of her demise 2,000 cc. of glucose intravenously. She expired rather unexpectedly and quietly on her eighth hospital day. The clinical impression was that of possible carcinoma of the cecum, luetic heart disease, cirrhosis of the liver, and generalized arteriosclerosis with brain involvement.

CLINICAL DISCUSSION

DR. B. K. WISEMAN: This case presents one diagnostic difficulty in that the history is not of a great deal of value except for the statement that the individual was in a confused state. This patient did have relatives but it is not clear why some kind of history was not obtained from them since all efforts directed toward the patient did not produce any reliable facts. She did say that she had a pain in the chest of about six weeks' duration. But if you read these things over you have a good deal of doubt in your mind as to how much significance you should attach to them, because the individual was disoriented and it was stated that she gave different answers to different interrogators. So that one cannot really put any very strong reliance on anything in the history, it seems to me, except that she undoubtedly was in a confused state.

There was something wrong with her cere-

bration. This is a considerable handicap in making a diagnosis. Personally I like to approach clinical problems by obtaining the best history I can and then come to a tentative conclusion solely on the basis of the history. We used to have some clinics around here where we brought unknown patients up on the platform and tried to make the diagnosis solely from the history. Afterwards we would check to see if the laboratory and the physical findings changed our original impression. Of course many times it did, but you would be surprised to learn how many times we could arrive at an accurate diagnosis on the basis of the history alone.

MENTALLY CONFUSED

Whether she had a pain in her chest or not, I don't know. It is stated that she had some nonproductive cough in the morning, associated with emesis and some shortness of breath. Again that is difficult to evaluate. She was supposed to have lost 30 pounds in weight. I am inclined to discard almost all that history and simply accept the only fact worth taking into consideration, that she was mentally confused.

Now when we come to the physical examination I think we begin to get better results. The blood pressure was stated to be 154/110, and she might have been slightly hypertensive. She was lethargic, slow to comprehend, and quite confused. We come now to the most important organ—the heart. It says here that "it was enlarged to the anterior axillary line and a harsh systolic and diastolic murmur could be heard over the apex and along the left sternal border." This somewhat indicates an area where one would expect to find murmurs from either the pulmonic or aortic valve. Diastolic murmurs of the aortic valve are best heard along the left side of the sternum and in the third interspace on the left chest. So I would think that the systolic and diastolic murmur originated in the aortic valve, although there might be some doubt about that from the uncertainty of the statement.

LIPOMA

The finding of a soft nontender mass palpable in the left lower abdominal quadrant was quite correctly interpreted by various consultants as a harmless lipoma. The diagnosis of generalized arteriosclerosis with brain involvement seems justified, as I think we all agree that she had some brain involvement. I think one of the best statements in this chart is that of the intern, who after going over all this history and taking the physical examination wrote down, "I don't know." But I don't think he should have said that, because during the physical examination he should have remembered some of the truisms in clinical medicine that many of us forget in these days of the electron microscope, paper electrophoresis and spectrophotometers.

One rule which you should not forget, unless

this case does not turn out the way I think it ought to, is that anybody who has fever and a heart valve murmur should immediately be suspected of having subacute bacterial endocarditis, particularly if fever lasts for as long as a week and cannot be explained otherwise. Then if in addition the patient has a confused mental state, it is even more important to consider that diagnosis, because you know that one of the important features of bacterial endocarditis is the throwing off of emboli in all directions with embolization of small brain vessels resulting in focal areas of encephalomalacia and a stuporous or confused state.

The laboratory data, I think, again reinforce our clinical impression that this patient could have subacute bacterial endocarditis. There was a mild anemia of the normochromic type, which is the thing you expect in this disease. The urine did contain some red cells and albumin, again indicating possible embolization of the kidneys.

VALID BLOOD CULTURE

Then finally, and most important of all, a blood culture, which was taken rather belatedly in my opinion, was positive for alpha streptococcus. I think it is pretty uncommon to get an alpha streptococcus as a contaminant in a blood culture, and I would be inclined to believe, particularly in association with the physical examination, that this probably was a valid septic growth in the blood stream. It seems they took a lot of x-rays and came up with practically nothing. Her hospital course was febrile throughout her stay. She ran temperatures from 100° to 103° for eight days and finally expired suddenly.

Well, there is your case. You see the information is not very great. It seems to me, however, that there is enough information here to warrant a tentative diagnosis of subacute bacterial endocarditis. I would certainly favor it far beyond any other diagnosis that might account for this train of circumstances. She has, I think, about every sign and symptom you would like except that you would like to feel an enlarged spleen, but you must recall that in at least half the cases of subacute bacterial endocarditis the spleen never gets large enough to become palpable. You like to have the history of fleeting pains throughout the body. Maybe she had those and the history is deficient on that. You like to find petechiae on the skin, Osler nodes and splinter hemorrhages under the nails, but again those findings are not always present. But she did have prolonged fever, anemia, heart valve murmurs, and at least one blood culture with alpha streptococci. It seems to me that all those findings pretty well suggest subacute bacterial endocarditis and I can hardly explain all of them by any other diagnosis.

What could some of the other possibilities be? With a chronic infection of some kind in a

colored woman of 62 we always think first of tuberculosis. But we find no evidence here that this individual did have tuberculosis. Her chest plate does not show tuberculosis. A spinal puncture was done and she did not have tuberculous meningitis. There is no reason to believe that she had tuberculosis, but of course we have seen patients come to postmortem in whom the finding of a miliary tuberculosis came as a surprise. I would think therefore that you should include tuberculosis in the list of possibilities.

Brucellosis usually is not fatal and so I don't think we should consider this, and I think that if she had a systemic fungus infection which would give her septic symptoms like this the fungus ought to be found. Of the infectious group which is likely to produce similar symptoms and cause death, tuberculosis is about the only thing I can think of, and we don't have any evidence that tuberculosis played any part in this individual's downhill course and death.

COLLAGEN DISEASE?

The collagen diseases of course always have to come into consideration and could of course actually produce heart murmurs. I am thinking here of Libman-Sack's type of endocarditis, which is a verrucous endocarditis associated with a disseminated type of lupus erythematosus. Against this diagnosis rests the fact that a bone marrow examination failed to discover LE cells, which are always present in an advanced state of lupus disseminatus.

Malignant tumors can cause death of patients and are sometimes not detected before the autopsy, but really we do not have much clinical evidence for cancer in this patient. The gastrointestinal studies and all other examinations do not support the diagnosis of an occult neoplasm with metastases to the brain. The case just does not sound like a malignancy.

So we have to go back to subacute bacterial endocarditis to explain this individual's illness and death. It may be, as stated in the history here, although again I am not prepared to believe anything in that history, that she did have an episode similar to this before when she lost 20 pounds and got well. That happens in subacute bacterial endocarditis. They get a bacteremia and then the lesions heal temporarily, but after a while the valve becomes again infected and the patients finally die.

I think it is unfortunate that bacterial endocarditis was not considered right away in this patient. It is a disease that we can cure today with antibiotics. Ninety per cent of bacterial endocarditis of the subacute type is due to this green streptococcus, and out of this group I believe almost 100 per cent can be cured by the proper antibiotic therapy. It is quite likely, I think, that by the time she came to this hospital her lesions were advanced beyond the stage where she could have been rescued. The point

I am trying to drive home is that subacute bacterial endocarditis ought to have been thought of promptly in this individual and steps should have been taken to rule it in or out, because it is now a curable disease and I think that our responsibilities increase in direct proportion to the assistance we can give patients.

I will conclude this discussion then by stating that I think she had subacute bacterial endocarditis and that I don't see any other disease that could fully explain her clinical picture. So I am going to expect the autopsy to show areas of encephalomalacia in the brain to account for the confused state she was in. I would expect her to have a vegetative endocarditis most likely affecting the aortic valve. I think she could have a focal glomerular nephritis, and I would think she would have an acute splenitis and some of the other lesions that go along with a 62 year old person with arteriosclerosis. But I believe the autopsy essentially ought to show in this patient a subacute bacterial endocarditis.

GENERAL CLINICAL DISCUSSION

DR. J. R. HUSTON: How about the white blood picture, Dr. Wiseman?

DR. WISEMAN: The white blood picture was essentially normal and I believe that in more than half the cases of subacute bacterial endocarditis it is normal. The textbooks say there is a leukocytosis in subacute bacterial endocarditis, but actually that is not the fact. I think in at least half of them you get a blood count just like this—a normochromic type of anemia and a white count essentially unaltered. I tried my best to make a hematologic case out of this since I have a special interest in hematology, but I could not do it. I think that her blood picture was secondary to whatever she had, and it would certainly conform with the pattern one would expect in a subacute bacterial endocarditis.

MEDICAL STUDENT: The history states that she was afebrile for several days in her hospital course. Is that typical of subacute bacterial endocarditis?

DR. WISEMAN: Yes, that is quite typical of subacute bacterial endocarditis. They will go for a day or so without any fever at all and then they will spike for a couple days, or they may run a persistent spiking fever, not very high, usually not higher than 103.

CLINICAL DIAGNOSIS

1. Subacute bacterial endocarditis (aortic valve).
2. Embolization to brain and kidneys.
3. Generalized arteriosclerosis.
4. Lipoma.

PATHOLOGICAL DIAGNOSIS

1. Subacute bacterial endocarditis (aortic valve).

2. Suppurative myocarditis.
3. Rheumatic heart disease, old, with:
 - (a) old aortic valvulitis.
4. Pulmonary edema with early bronchopneumonia.
5. Septic splenitis.
6. Old chronic pyelonephritis.
7. Arteriosclerotic brain disease with old encephalomalacia in basal ganglia and frontal lobe.
8. Septic emboli and petechiae of pons.
9. Lipoma.

PATHOLOGICAL DISCUSSION

DR. EMMERICH VON HAAM: I chose this case because of the many diagnoses suggested by the medical department, most of which proved incorrect at autopsy. When we knew that Dr. Wiseman was going to lead the clinical discussion we picked this case for him as a diagnostic problem, but it apparently was no problem for the old master.

The body was that of a well-developed, poorly nourished colored female. The heart was enlarged with hypertrophy of the left ventricle. The mitral, tricuspid and pulmonary valves were normal. The aortic valve showed two types of lesions: fine calcific plaques and large soft and friable vegetations. The coronary vessels were perfectly normal, and there was no other gross lesion suggestive of previous rheumatic heart disease. The lungs weighed 800 and 600 grams and showed considerable edema with some nodularity suggestive of early bronchopneumonia.

The spleen was enlarged and weighed 250 grams. A 250 gram spleen, I would say, is barely palpable and you may just feel the lower pole if you are very careful. The liver was slightly enlarged and congested. The gallbladder and pancreas were normal. The gastrointestinal tract showed some very superficial ulcerations in the ascending colon just above the cecum. We were not sure whether these represented embolic lesions or if they were stercoral ulcers, because feces were impacted in the intestinal tract.

The kidneys were of normal size and showed deep flat scars and small cysts. They were the kidneys of an old hypertensive person who did not show any true renal insufficiency but demonstrated the anatomical basis for renal hypertension. The sex organs were involuted. The abdominal aorta showed moderate arteriosclerosis. The palpable tumor in the left inguinal region proved to be a lipoma.

The brain was of normal size and showed some depressed cortical zones, one in the frontal lobe, and several small areas of encephalomalacia in the basal ganglia. They were cystic and must be considered old lesions. The pons showed many recent petechiae. We stained smears from the vegetations and found streptococci with some other cocci and Gram-negative rods suggesting

that the patient did have an agonal mixed type of bacteremia.

MICROSCOPIC EXAMINATION

Sections through the myocardium proved that the patient did have an old healed rheumatic myocarditis with typical perivascular fibrosis. Other sections showed an acute infiltration of the myocardium with polymorphonuclear leukocytes representing an acute suppurative myocarditis, which is found not infrequently as a complication of bacterial endocarditis. It may produce sudden death due to ventricular fibrillation. Section through the aortic valve showed fibrous thickenings of the valve, again suggesting a healed rheumatic valvulitis. The vegetations covered most of the valvular surface and contained many large bacterial colonies which demonstrated the coils and chains of streptococci.

Sections through the lung showed edema with small scattered foci of early bronchopneumonia. The spleen showed an acute splenitis with necrosis of the malpighian corpuscles. Acute congestion was found in the liver as seen in cases of right heart failure. The kidneys showed the pictures of senile nephrosclerosis, a mild degree of arteriolar sclerosis and chronic pyelonephritis. Examination of the brain revealed the petechiae of the pons to represent hemorrhagic embolic lesions with many polymorphonuclear leukocytes in or around the focal hemorrhages. So you see that Dr. Wiseman's prediction that the lethargy of the patient was caused by bacterial embolism was perfectly correct.

Since we could also consider the hemorrhages in the pons a fatal lesion, we have two choices to explain the sudden and unexpected demise of the patient. We can argue that the patient died from a fatal embolism in the pons or medulla, or we can state that the patient died from septic myocarditis. Death from either lesion is rapid and quiet, and both lesions are fatal. The brain also showed many foci of old encephalomalacia, probably on an arteriosclerotic basis. The possibility of old embolic lesion cannot be definitely ruled out, but the renal and vascular pathology of the patient makes cerebral arteriosclerosis much more likely.

We then have a pathological diagnosis which is in perfect agreement with the one made by our clinical discussant. The patient did suffer from a subacute bacterial endocarditis which was not recognized before death and which was superimposed, as they so often are, upon a healed rheumatic lesion of the aortic valve. In addition the patient suffered from a moderate hypertensive cardiovascular-renal disease with cerebral arteriosclerosis.

GENERAL DISCUSSION

DR. WISEMAN: I can only reinforce my previous statement that anybody who has a fever for as long as a week, and a heart murmur, should be suspected of subacute bacterial endocarditis.

DR. VON HAAM: Don't you think that her fever should have been more pronounced and that the patient should have had chills?

DR. WISEMAN: No, too many of them die like this patient here and do not have chills or high fever. I would say that in anybody who has an unexplained fever for as long as a week, think of the possibility of a bacteremia and a subacute bacterial endocarditis. You will be surprised how many individuals with subacute bacterial endocarditis have no detectable heart murmurs, and sooner or later everybody is going to miss this diagnosis. I have missed it but I am not going to do it again, I hope.

MEDICAL STUDENT: How about the age of the patient?

DR. WISEMAN: The age is another thing. Your question reminds me of a lesson I was taught by the late Dr. Sol. Hatfield, who was a professor of Medicine in this institution and a very fine clinician. We had a 76 year old woman on the ward with fever and the same sort of inconclusive history. I made the statement to Dr. Hatfield that I did not think a person of that age would be likely to have subacute bacterial endocarditis. He contradicted me and was correct, and since that time I have found many patients in the older age range with this disease. The textbooks say that the preferred age is between 15 and 30, but actually I suggest that you look out for the older people. There are quite a few of them with subacute or acute bacterial endocarditis.

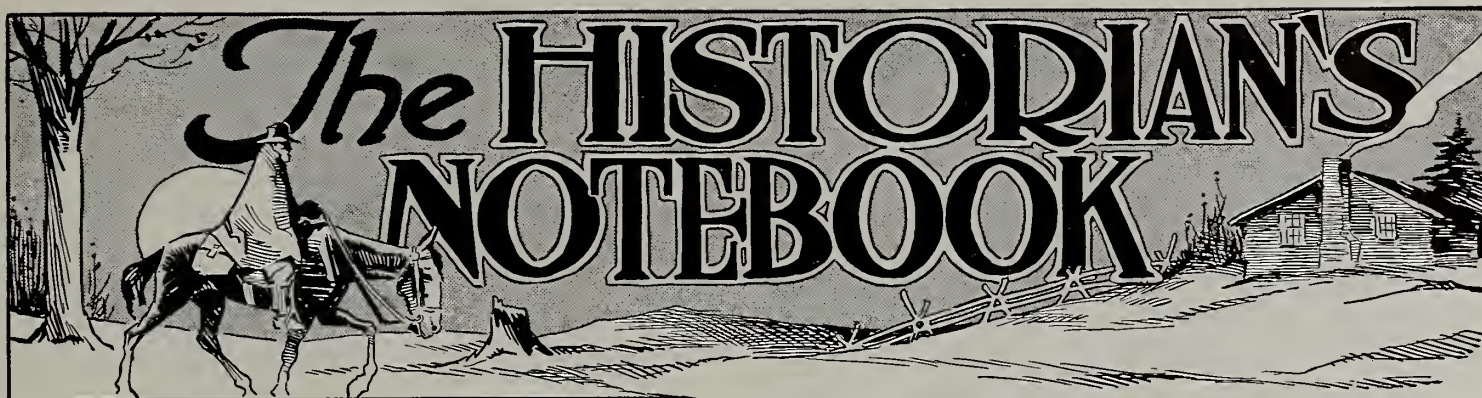
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Multiple Entities May Explain Discrepancies in Therapy of Rheumatoid Arthritis

I would like to introduce the possibility that we are at present about as accurate in our diagnoses of rheumatoid arthritis as our forefathers were of pneumonia 50 years ago. Maybe we are dealing with more than one disease process which would explain the discrepancies in therapy noted so frequently. . . .

To me no solution for the suppression of this dreaded scourge is forthcoming until we face the fact that nothing is accomplished by the use of cortisone and its analogues except to fatten the purses of some and flatten the purses of others. Some method must be found which will give 100 per cent results in producing cure of all active disease. A mode of action for our presently available substances must be found. Only then will the etiology be forthcoming and preventive steps be elaborated to make arthritis a medical curiosity.—Bruce Zimmerman, M. D., Seattle, Wash: *Northwest Medicine*, 55:422, April, 1956.



Some Excerpts from the 1837 Case Report Books of the Commercial Hospital and Lunatic Asylum Of the State of Ohio

LEON GOLDMAN, M. D.

I AM sure that there are very few staff meetings at hospitals where at least someone, or some committee, does not continue to make pleas for better records of patients. Those of you who have had the unenviable job of attempting to excavate material from hospital records will be properly sympathetic.

It is of interest, then, to go back to the old records of the Commercial Hospital and Lunatic Asylum.

THE HOSPITAL

As you know, through the initiative of Daniel Drake, this first public hospital in Cincinnati was created by an Act of the Legislature on January 22, 1821. It is interesting to note that this was built on the very grounds where the old Cincinnati General Hospital stood on the square bounded by Twelfth and Central, Ann and Plum, now just a parking lot across from the Music Hall. At this time, it was on the outskirts of Cincinnati; originally, it was to be used for lunatics. In 1832, the bed capacity was listed as 150. The professors of the Medical College of Ohio were in charge; one for medical and one for surgical services.

JOHN T. SHOTWELL

On March 10, 1837, in the record book, John T. Shotwell wrote "There is not a single record in the medical department nor a single instrument in good repair. Most of the cases of instruments have lost one or more important pieces." (Fig. 1.) This successful physician is called by Juettner, one of the foremost characters in the history of the Medical College of Ohio. "He loved and admired John T. Shotwell better than everybody and everything on earth." He was a cousin of Daniel Drake and read medicine in Drake's office.

The Author

● Dr. Goldman, Cincinnati, is director of dermatology, Cincinnati General and Children's Hospitals; professor of dermatology and syphilology, University of Cincinnati College of Medicine.

A scheming and powerful politician, with most of the faculty gone, he elected himself Dean in 1837. The fight over privileges in the Commercial Hospital between his cousin, rival and enemy, Daniel Drake, caused Drake to call Shotwell "a falsifier, a coward, an ingrate, a dishonorable competitor." Evidently, notwithstanding, he was a charming and cultured man, and well liked by the students. Yet his activities at the college were called "not constructive, demoralizing and distintegrating." Save for this one note, the case books give no hint, at least in these books given, of his violent struggle in this hospital,

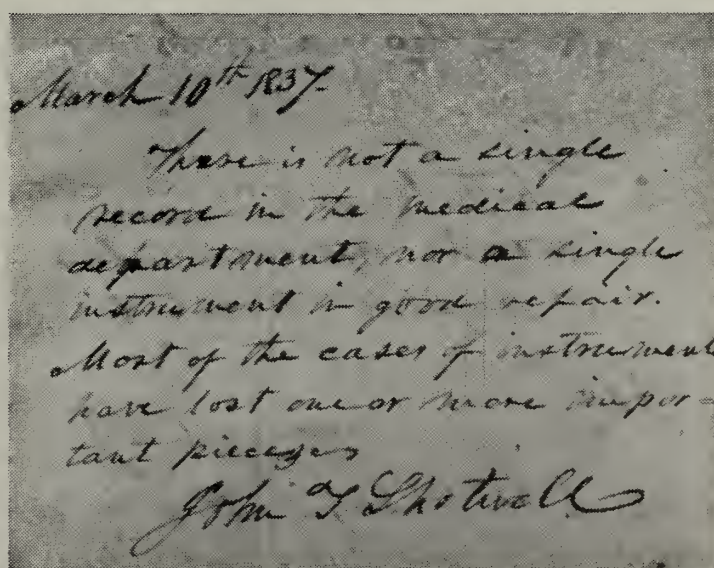


Figure 1

From The Department of Dermatology and Syphilology of the College of Medicine of the University of Cincinnati.

Read at The Ohio Academy of Medical History at Columbus, on April 30, 1955.

terminated rather abruptly by his untimely death from cholera in 1850.

In 1827, the position of intern, or really resident physician, was established at an annual salary of \$400. Although our interns today may get almost the same, this intern really was in charge, and some of the interns of this hospital include some of the most distinguished names in the medical history of the West.

JESSE P. JUDKINS

In this report, we are concerned with Jesse P. Judkins, member of a family of physicians. He was a brilliant anatomist. He is named as a matriculant at the Medical College of Ohio in 1836, and graduating in 1838; and later, becoming a demonstrator of anatomy in 1839 under Shotwell. In 1837, however, he is listed as Resident Physician (fig. 2). In 1847, he was

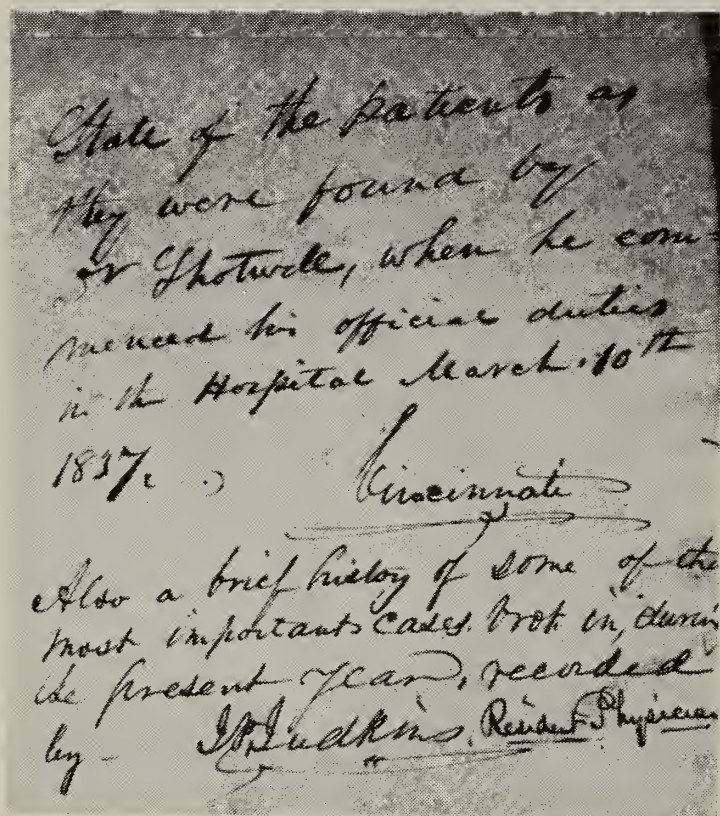


Figure 2

professor of anatomy at Starling Medical College of Columbus; later, professor of surgical anatomy and pathology at Miami Medical College, and even later, professor of descriptive anatomy with the consolidation of the Ohio and Miami Colleges.

We see little, however, of the age-old fight for hospital privileges in these sparse, but definitely not barren, case reports.

THE PATIENTS—FOLKS FROM THE CITY AND THE RIVER

The case books are old-fashioned ledger type of books, measuring 6 by 14½ inches with hard board covers, and labelled as Medical Ward, Vol. I. The Surgical Ward book is indeed shopworn, and listed on the cover as *Clinicum Chirurgicum*. Doodling of the 1837 variety occupies the inside covers. In the medical book, on inside covers, appear the names of Shotwell and Judkins. No names were found on the inside covers of the

surgical book. The cases are those of the people of the community, and especially, the boatmen along the Ohio River. This hospital at that time was what may be called a very important marine hospital, although it was far from the river and was needed for the accidents, illnesses and brawls along this turbulent river.

Alan Huckleberry of Muncie, describes the boatman who was probably still going in 1837, although gradually to be replaced by men of the steamboats: "In physical makeup, he was tall, thin, and sinewy. His immobile face was tanned to a dark brown; from above high cheekbones and a long nose, two grey eyes gazed blankly. In his normal state, he was silently waiting for something to happen. When the bomb of circumstance exploded, he was instantly transformed into a combination of rubber ball, wildcat, and shrieking maniac, all controlled by instantaneous perception and exact calculation. After the tumult, he subsided again into his listless lethargy of waiting, the monotony being endured by chewing tobacco and demonstrating the marvelous accuracy with which he could propel a stream of juice for any distance up to 15 feet. The boatmen prided themselves in this art and often passed the time by making wagers on whether or not they could hit a knothole or a fly."

THE MEDICAL BOOK

The medical ward book, probably male ward only, gives us a picture of Medicine of that time: fevers—including malaria, (fig. 3) "typhus,"

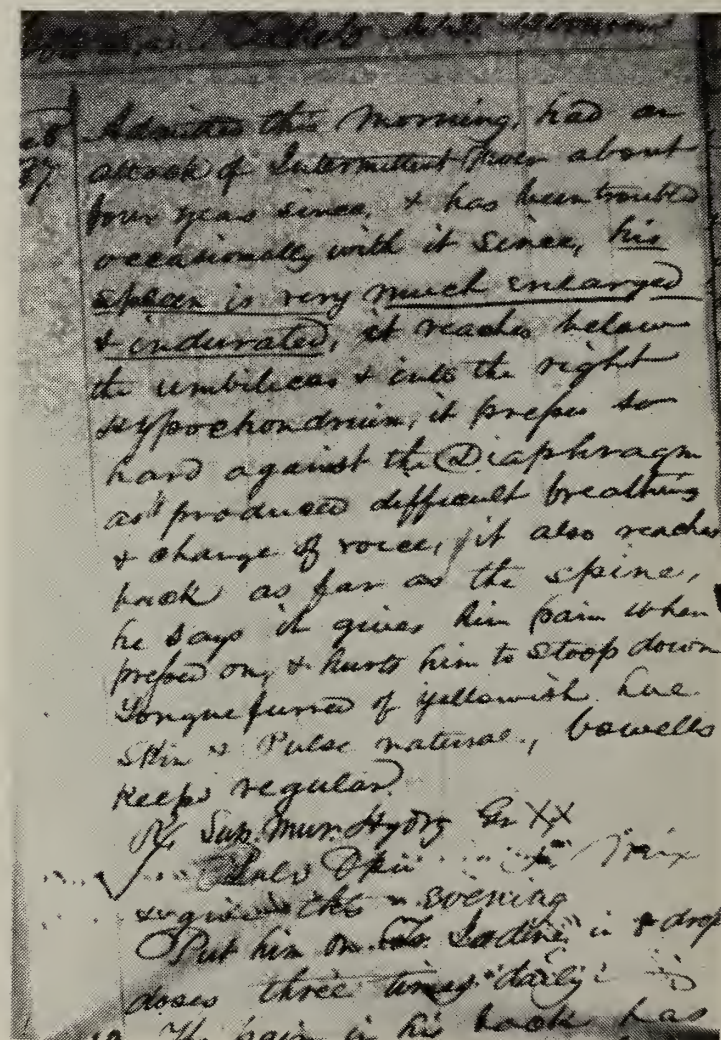


Figure 3

"typhoid states" and much diarrhea (treated with Dover's Powder), and much alcoholism with delirium treated with tartar emetic. Personal notes may be found in one case of alcoholism:

"M. O., age 58, labourer. August 30, 1837, admitted today. Says he has been sick seven months for ulcers in mouth, pain in breast. As he seems rather stupid, probably 'tight,' I shall wait a few hours before further examination.

"September 11th—Time enough in all conscience has elapsed for the fumes of liquor to have passed—etc."

A case of chickenpox, not isolated, is reported and a "varioid sent to the Pest House," across the street where the Music Hall now stands.

Deaths are reported and an occasional detailed postmortem done.

Personal notes are also included as one alcoholic who was listed as "Printer and Poet": "April 25, 1837—This man writes beautiful poetry; 28th—has published a piece called "Queen of the West" in the *Gazette* of this day.

There is also a note of another patient in extremis, "can scarcely arouse him by hollering in his ear."

Calomel was certainly a commonly used medicine (Even in 1926, I can recall some of Dr. Martin Fischer's polemics!). The last case in the book is one of consultation with John Moorehead, called "Old Hydrarg," because he loved blue mass and calomel so much. However, for the swollen joint of the last case in the Medical Book, he advised "to continue alternate blisters above and below the knee and to rub the joint with camphorated blue ointment." Still faithful unto mercury!

THE SURGICAL WARD BOOK

According to the Surgical Ward Book, the male ward, at least, must have been Some Place! The first thing that impresses one is the emphasis on dermatological material. There were tremendous numbers of leg ulcers of all sizes and shapes. (Fig. 4.) In 1955, the commonest cases on the dermatological service at the Cincinnati General Hospital and the longest period of hospitalization on the ward, are the leg ulcers and stasis syndromes.

"M. B., act 38, lab. January 25, 1838.—Admitted today with an enormous ulcer on right leg of three months duration, of an intemperate habit; 27—apply a series of poultices; 31—apply compression with 'strapes' every two days, also a solution of antimony. February 3rd—ulcer looks better, leg softer, continue; 7th—continue same; 17th—adhesive straps for compression."

In 1949, Oscar Gilje of the Dermatological Department of the University Hospital of Oslo, after an extensive study of the dynamics of *ulcus cruris* concluded that tight adhesive compression is best ambulatory therapy. Today, this Gilje treatment is again in use in the offspring of the old Commercial Hospital.

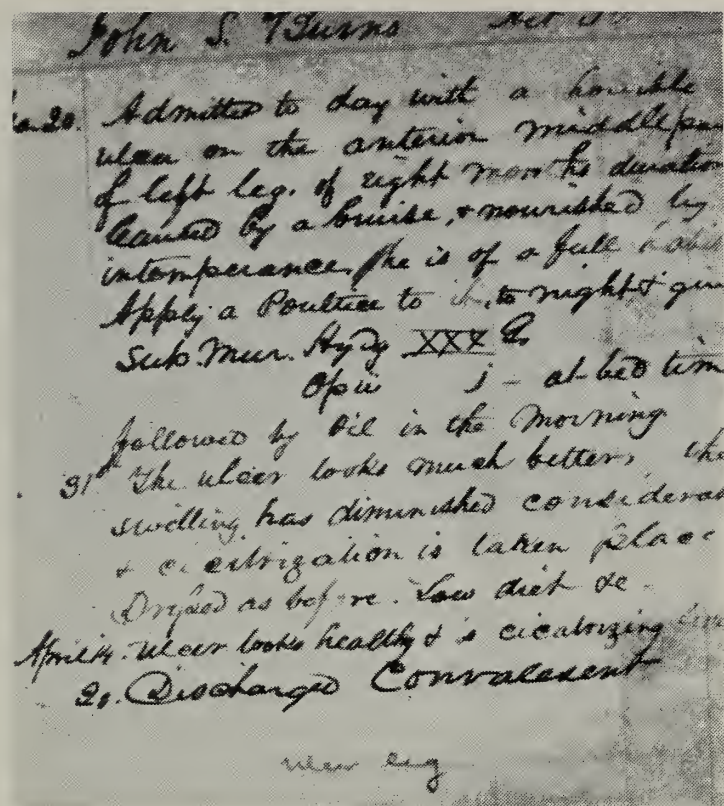


Figure 4

There was much syphilis of all stages, including one possible case of malignant syphilis, which Dr. Jared Potter Kirtland, also a famed naturalist, gave quinine. One case of chancre with paraphimosis was "inclined to act the rascal in which not being indulged, he wishes to leave; permission granted." Acquiring syphilis is called in this book "tainted with syphilis." One extensive ulceration, suspicious of late syphilis, is described as "in relation to his infirmity, we might well exclaim in the language of the philanthropist: Alas poor human nature!" Therapy for syphilis included sarsaparilla guaiac, mercury in all forms and iodine. Gonorrhea was treated with balsam copaiba as we used in urology clinic at the Cincinnati General Hospital in 1926.

Scabies and various types of dermatoses were present also on this ward. One severe eczema of the hand was treated with calomel and jalap, and locally, given soap and ung. terebinthinae and discharged as cured in 13 days. Today, we are doing investigative studies regarding the effect of soap immersion on "eczema of the hands," and studying the incidence of turpentine hypersensitivity in "eczema of the hands."

Of course, trauma such as fractures, steamboat explosions, burns, tetany were found. Slippery elm poultices were used for burns and dog bites.

In the Surgical Book, many more staff men were given mention and also flattering phrases. For a case of severe leg and foot injury of two weeks, "Professor Shotwell in the presence of Dr. Robert Morehead and numerous professional gentlemen amputated the leg a few inches below the patella, performing the operation with great skill and dispatch." Later, it is indicated that the patient developed gangrene and died. Professor Mussey also treated eye cases (some from

Drake's Hospital) and removed polyps from the nose. Professor Marmaduke Burr Wright is also mentioned.

The incompleteness of the record is also exhibited. (Fig. 5.) This reminds one of the dif-

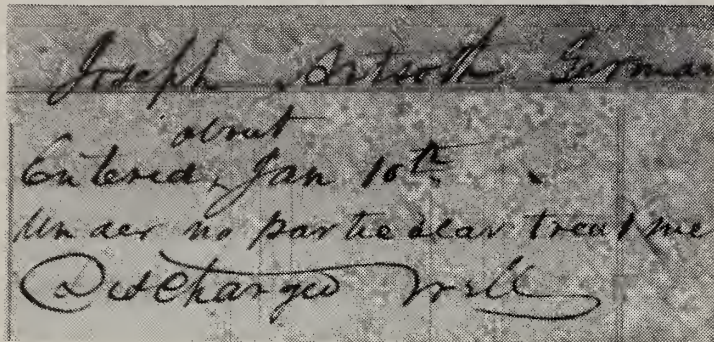


Figure 5

ficulties of the late Dr. H. H. Langdon, assistant superintendent of the Cincinnati General Hospital, who whenever he had any of the residents on the threadbare carpet in regard to their incomplete charts, was always reminded of his own very famous record. When he was a resident on medicine, one of his charts was composed of only three lines. The first line read "History suggested pleurisy with effusion"; second line, "Examination showed pleurisy with effusion"; and third line, "Tap showed pleurisy with effusion."

These 1837 case books then provide a good cross section of American Medicine of that period. They show clearly the value of the hospital for clinical teaching. It is a great tribute to Daniel Drake, who fought for the development of this type of hospital, even though it served as an arena for his severest critics and actual sparring partners who walked the wards.

I am certain that our own voluminous records, chiefly piles of laboratory slips, will not be as interesting or perhaps even as instructive in 2073.

Legion Post In Athens Bears Name of Physician

Dr. Kossuth T. Crossen, for whom the Athens American Legion Post was named, is described in a historical account written by Miles H. Cagg, charter member and historian of the Post, the *Athens Messenger* reported on April 18.

Dr. Crossen practiced in Carbondale, Jerseyville and Albany, all in Athens County, before he went into service during World War I. He passed up the Medical Corps and chose to become an Infantry officer. Captain Crossen was mortally wounded while leading his command in the Battle of the Marne, July, 1918.

Erratum

In the May Historian's Notebook article entitled "Rise and Decline of Freudianism," a misplaced line at the end of page 502 read, "psychoanalytic terminology. But such basic psy-"; the line should have read: "psychotherapists, among them Arthur Kronfeld."

Franklin County Pelvic Cancer Delay Committee Report

By JOHN H. HOLZAEFFEL, M. D.
Columbus, Ohio, Chairman

The Franklin County Pelvic Cancer Delay Committee met on March 21, 1956, at 12 o'clock noon. Three cases were presented.

Case 1: A 45 year old female in April, 1955, gave history of not feeling well since past Christmas. Family physician saw her three weeks prior to her referral. A gastrointestinal series was negative. Blood count revealed too many white cells. Only symptoms were of pelvic discomfort on right side, bloating, and distension. Examination revealed excess of fluid. Cervix was seen and in place. A subtotal hysterectomy had been done at the age of 36.

Patient was admitted to St. Ann's Hospital where paracentesis was done and 4,300 cc. of cystic fluid were removed. Peritoneoscopy revealed irritation. Diagnosis was papillary carcinoma of the ovary, Grade III. Seen June 17 and was receiving x-ray therapy. No distension and no evidence of fluid. In September, examination was negative. Returned March 20, 1956, with no symptoms other than constipation. Examination revealed hard thickened area in pelvis. At time of operation left ovarian tumor was removed. Ascites was present. Evidence of recurrence.

Comment: *Dr. Edwin Zartman:* Cure rate is low, but there might be more chance if laparotomy is done early.

Case 2: Age 35, gravida I, Para 0, ectopic six years ago with surgery and procedure six years prior with cystic tube. Symptoms thought by family physician to be menopausal. Punch biopsy was done and pathological report was carcinoma of cervix; question was whether the carcinoma was pre-invasive or invasive. Referred to gynecologist. Nothing else found on examination; palpation of cervix was not remarkable. Admitted for dilatation and curettage which was negative. A cold knife conization was done and reported negative. It was then decided to perform a hysterectomy and the specimen when examined, was negative. No carcinoma.

Comment: *Dr. Harry Ezell:* The fact that cold knife conization was negative, ruled out invasive carcinoma.

Case 3: A 43 year old female who first noticed symptoms in June, 1952, were of para-urethral mass increasing in size for past year, but nontender. In 1953 patient was afflicted with what appeared to be pelvic inflammatory disease and was seen by physician. Lesion was noted at this time, but there was no biopsy. Pan-hysterectomy and bilateral salpingo-oophorectomy were done June 16, 1953. She was not seen until February 28, 1956, when she reported to the Gynecologic Tumor Clinic. Symptoms were of bleeding for past three weeks. Examination revealed a 4 cm. lesion on right labia minora. It was freely movable with right superficial inguinal node involvement. Patient was admitted to the hospital where a bilateral groin, radical vulvectomy and node dissection was done.

Comments: *Dr. Fred Hapke:* Patient delay of a year between symptoms and first consultation with physician, and again following operation and time of reporting to clinic.

Dr. Frank Hugenberger: Why was there no biopsy or Papanicolaou smear done in office at time of first consultation?

Ohio's Program for Crippled Children...

Physician's Role in One of State's Important Medical and Hospital Activities Described by Medical Director in Talk to Heart Association

AN excellent description of Ohio's Services for Crippled Children was given by Dr. Nathan P. Eisenberg, medical director of the services, in an address, "The Physician's Role in Ohio's Crippled Children Program," at a meeting April 9 of the Ohio State Heart Association in Cleveland.

The Journal secured the permission of Dr. Eisenberg and the Heart Association to publish this somewhat condensed transcript of Dr. Eisenberg's talk, believing that it would be of informative value to Ohio physicians. Following are substantial excerpts from Dr. Eisenberg's review of the Ohio Services for Crippled Children:

* * *

The State of Ohio has a functioning program for the rehabilitation of its crippled children. The program in Ohio is financed by Federal funds and amounts appropriated by the State Legislature and the individual counties.

TYPES OF CASES COVERED

When the concept of the care and the rehabilitation of its crippled children became a State responsibility, it was necessary, among other things, for Ohio to define the types of cases which would be included in such a program.

Defining a "Crippled Child" then, meant a literal and narrow interpretation—a visible, physical defect involving an extremity or the spine. This meant a purely orthopedic project, and therefore the only physicians to participate were orthopedic specialists who actually pioneered the Crippled Children's Services in all the 48 states.

At a later date, rehabilitation efforts included plastic cases such as cleft palate and skin grafting. This necessitated plastic surgeons being added to our services.

When standards were set up to determine qualifications for those permitted to operate upon State cases, such standards were decided upon by members of a Medical Advisory Board consisting of plastic and orthopedic surgeons.

Today, the same strict standards apply to these two groups namely, being members of their specialty boards in addition to being approved individually by each component member of our Medical Advisory Board which at present consists of all the main specialty groups. This more inclusive membership of the board as compared with its original components of only orthopedic and plastic surgeons, demonstrates how the program has evolved through the years

to be far more inclusive as to the types of cases acceptable for state care and rehabilitation.

CATEGORIES INCLUDED

Today, we include under our rehabilitative services the following categories:

- (a) All congenital deformities amenable to surgery
- (b) Congenital cardiac cases amenable to surgery
- (c) Cleft palate cases
- (d) Plastic repairs
- (e) Eye cases amenable to surgery
- (f) All orthopedic types of cases including cerebral palsy, paralytic polio, bone tumors, etc.
- (g) Hard of hearing cases amenable to surgery

All the above categories must be rehabilitable, from both the mental and physical aspects. All related therapies required such as speech, occupational and physiotherapies, braces, prosthetic appliances, etc., which today are all included in any highly standardized rehabilitation center, are paid for under the Crippled Children Services.

WHEN IS CASE DISCHARGED?

As long as the family is financially eligible, the case is under State care and discharged from such care when the following apply:—

- (1) Change in the financial family picture
- (2) Death of the patient
- (3) Residence in another state
- (4) The physician's statement that the child has attained maximum benefit from all treatments
- (5) Request of the family to remove child from State care
- (6) Attaining age 21 years
- (7) If after trial period, usually one year, a case is considered unable to benefit from treatments. These cases are most likely to be the most serious types of cerebral palsy and may require custodial care only.

HOW CASES ARE FOUND

The main sources whereby any case eligible to receive care under the C. C. S. comes to our attention are:—

- (1) The child's birth record. The Board of Health reports any child with a defect to the State Crippled Children's Services.
- (2) Private physicians, hospitals and hospital clinics;
- (3) Itinerant orthopedic clinics and diag-

nostic heart clinics sponsored by the State Crippled Children's Services with the cooperation of the interested county health department and the county medical society;

- (4) School health examinations;
- (5) Local health and welfare departments.

INVESTIGATIONS MADE

When the case is brought to our attention and state aid for medical care applied for, the interested physician, who must be a board certified specialist, fills out a Diagnosis and Plan of Treatment form which is sent to this department. The Medical Director then reviews this form and determines if the diagnosis makes the case eligible under our program and included under our diagnostic groups as listed above.

If the case passes this eligibility test, the department social worker then contacts the local county welfare or health department worker where the child resides and a social history of the family is requested.

The financial situation is next reviewed and in accordance with liberal and flexible financial standards, it is then determined if the case needs State aid. Factors such as family income, size of family, accumulated debts, unusual and unexpected expenses due to illness in family and unemployment are among many which are evaluated. Where insurance or other benefits can cover cost of a case, we tend to reject it. However, many cases are chronic and lengthy requiring much surgery, hospitalization, and rehabilitation. The major costs will then be absorbed by the Crippled Children's Services.

In the few instances where families can make small repayments, they are encouraged to do so. These sums are applied to the county credits so that many more services may be given to some counties.

QUESTIONS FREQUENTLY ASKED

An explanation of the financial aspects of the program are necessary as they relate to physicians since the following are some of the questions asked by physicians:

- (1) Do cases come under the State C. C. S. which can be legitimately contracted for and payment made for the services of private care? The answer is *No*. That is the reason for the social history. Furthermore, many of these cases have been under private care and the physician therefore knows the family's financial status and refers the case to us to continue under his supervision after it is accepted for care by our department.
- (2) Are physicians associated with our program generally satisfied with it and its operation? The answer is *Yes*, since all the physicians associated with us are in private practice. The Medical Advisory

Board which helps to establish fair fee schedules in payment for services rendered, are also physicians in private practice.

- (3) Another pertinent and interesting question is the extent of medical services given. Do we pay for all medical needs or only for those related to the reason for the child's acceptance for care by us? The answer is that we pay only for medical needs related to the diagnostic reason for the child being admitted for care to the Crippled Children's Services. Thus, we do not accept responsibility for routine dental needs, concurrent acute illness, etc. For us to enter into such fields of activity would not only defeat the concept of our program, but we would also be unable to administer it with the limited funds available.

HOW SERVICES HELP PHYSICIAN

Although the Crippled Children's Service is mainly of interest to the physician in a specialty and even more so to those interested in pediatrics, plastic, cardiac and orthopedic surgery, it is nevertheless important that all physicians understand the availability of these services in the state, those who are eligible and the aims and purposes of our program.

I stressed earlier that we in no way wish to interfere with the private practice of medicine. Now I wish to further stress that very often the family physician, knowing about our services, can direct the patient to an orthopedic, plastic or cardiac surgeon so that the child can receive the treatment needed. Thus, the knowledge and use of the system of "referrals" is necessary to all physicians as it relates to our program.

Another way in which our services help the family physician is the availability of our Diagnostic Heart Clinics. Not only have these served as an educational factor in the more isolated communities, but physicians have been encouraged to bring all types of cardiac problems in children to the team of specialists from a center as the Children's Hospital in Cincinnati. These cases are thoroughly worked up by the team and a report with recommendations is conveyed back to the referring physician.

More such clinics are in the process of formation and have already been approved by local county medical societies. Teams for these heart clinics will be staffed from Columbus and Cleveland and will travel as far as 100 miles from their centers of operation to bring a much needed facility to the rural areas.

NO COURT ACTION NECESSARY NOW

It is important to note here that up to September 22, 1955, cases could be placed under our

program only through the process of court commitment. Following action by the last legislature, this procedure is no longer necessary and may be applied only in the rare instance where parents definitely neglect and refuse the rehabilitation needs of the child. All our cases are now accepted by Crippled Children's Services directly upon application of the parents through the physician who will treat the child's specialized needs. Thus, cases come under our supervision more easily, more quickly and with greater satisfaction to all concerned.

SOME PAPER WORK NECESSARY

The Crippled Children's Services program is an extensive one, at times complicated and of necessity requiring many forms and paper work. We sympathize with the busy physician who reluctantly complies with many of the department's rules and regulations such as relate to billing for services rendered, prior request from the department for authority to hospitalize, do surgery or other procedures, request for consultations, etc. These, of course, are required in order to administer a large state-wide service both efficiently and economically.

One can well picture what is involved in caring for about 6,000 cases annually, and all the personnel and paper work necessary to move each case from its inception through treatment and on to termination of care or the attainment of maximum benefit from therapy. We, of the Crippled Children's Services can very well ask for tolerance and understanding of our problems from all the physicians, agencies and services cooperating with us. Not the least of this team concept is the invaluable role which the physician plays in our vast program.

MEDICAL ADVISORY BOARD

The Medical Advisory Board meets periodically to take up various problems, mainly relating to physicians and their proper place in our C. C. S. For example, at its next meeting, the Board will consider the need for the same requirements for such a new and expanding field as cardiac surgery as now apply to the physicians who may care for our plastic or orthopedic cases.

The needs and wishes of the medical professions are therefore well represented. Our unfortunate children of today are being helped to become future, happy and useful citizens through cooperative efforts of many services and agencies. Our physicians are no doubt happy to cooperate with the regulations and as they apply to specialty groups associated with the care of our children.

In summary, I wish to conclude by again stressing that the role of the physicians in our Crippled Children's Services program in Ohio is an important one and in fact the most important. For no one can doubt that there would be no such

available services to our children without them. It will be our continuing aim to work in unison towards an ever finer and better program. In that way our children who need rehabilitation will receive all the benefits of teamwork and good working relationships among all the services working toward one goal—to make these children fully useful and self-sufficient members of our society.

Ohio Physicians Asked To Help In Medical Statistical Project

Physicians in the vicinity of Cleveland, Akron, and Columbus are being requested to cooperate in a medical statistical research program, known as the National Disease and Therapeutic Index. The program is designed to provide information for the continuous study of the nature, scope and frequency of occurrence of disease in the United States.

Nearly 900 doctors, located in 27 statistically-selected, representative areas throughout the country, have agreed to participate in this project.

Established to meet a need for morbidity figures as opposed to mortality information, the program was discussed with top-level members of the American Medical Association staff; representatives of many state, county and local medical societies; a number of medical educators; and others in the medical profession before being put into operation.

The research facilities of Taylor, Harkins and Lea, of Philadelphia, have been utilized in the development and operation of the N. D. T. I. The program has the support of leading ethical pharmaceutical firms. Continuous liaison has been established with the Bureau of Economic Research of the American Medical Association to assure that the AMA will be prepared to receive and utilize all data concerning patterns of illness which appear to be of general medical interest. In addition, other organized medical groups and the nation's medical schools will be provided with usable data as they become available.

The data gathered will aid medical educators in planning and revising curricula; medical investigators in determining the direction and goal of research; doctors in efforts directed toward preventive medicine; health organizations in planning future programs; and pharmaceutical manufacturers in research and product development to meet current and future needs.

Each cooperating doctor is asked to report on the age, sex, diagnosis, and therapeutics administered or prescribed for each patient seen during the course of a 48 hour period once each quarter.

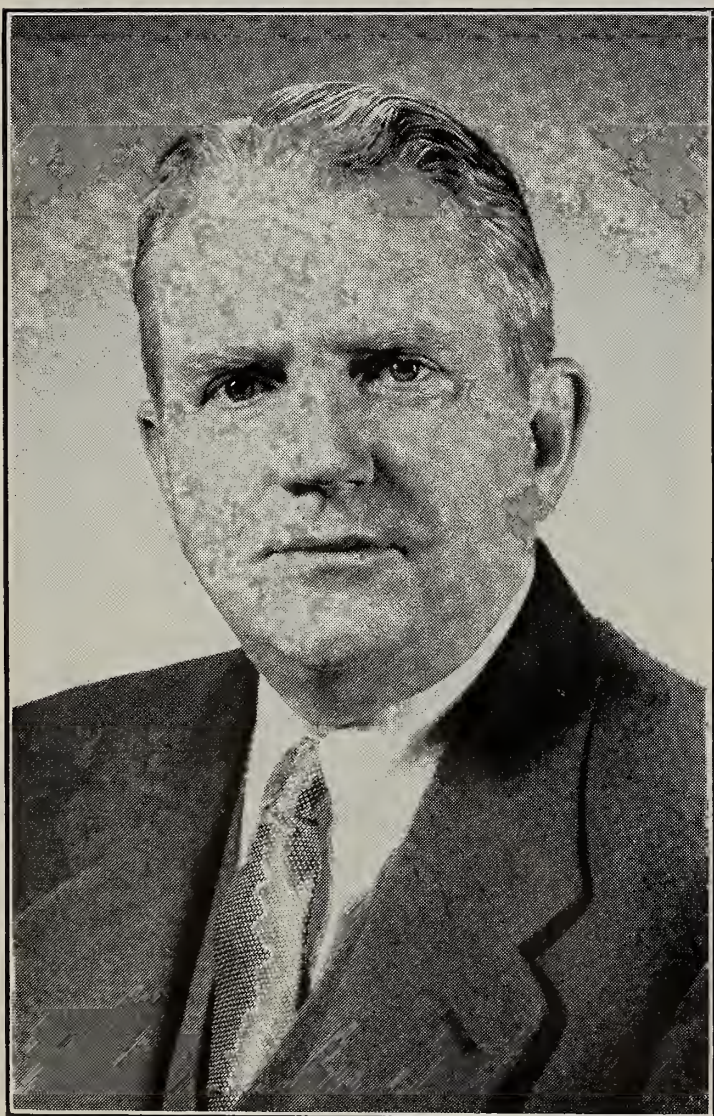
In each area a coordinator has been appointed, whose function is to assist in enlistment work, schedule reporting dates, and do preliminary coding of diagnoses. The coordinators are drawn from among residents, interns, and senior medical students in each area.

Presenting . . .

The New President, President-Elect, Treasurer and One New Councilor Elected at the Annual Meeting; Data on Other Members of The Council

THE HOUSE OF DELEGATES of the Ohio State Medical Association elected a President, a President-Elect, a Treasurer and one new Councilor at the 1956 Annual Meeting in Cleveland, April 10-12. The election of a President and President-Elect at the same meeting was unprecedented—necessitated by the death of Dr. David W. Heusinkveld, in the office of President. Following are biographical sketches of these newly elected officers as well as information on other members of The Council.

Dr. Richard L. Meiling was elected by the House of Delegates as President of the Association for the current term. Dr. Meiling is a practicing physician in Columbus, in the field of obstetrics and gynecology, and is Associate Dean of the Ohio State University College of Medicine and



RICHARD L. MEILING, M. D.

Associate Director of the OSU Health Center; also professor of obstetrics and gynecology and clinical instructor of pathology at the College and Center.

Dr. Meiling's record speaks for itself,

distinguishing him in the fields of medical practice, medical education, military medicine and medical organization. A native of Springfield, he received his early education in that city and graduated from Wittenberg College in 1930. He then studied medicine at Jefferson Medical College, later going to Germany where he studied first at the University of Erlangen and later at the University of Munich, where he received his medical degree in 1937. In 1950 Dr. Meiling received the Honorary Degree of Doctor of Science from Wittenberg College. In 1952 was invited to read a paper on use of radioactive substances in treatment of cancer of the cervix before the Congress of the Germany Gynecological Society in Munich and at that time received the Academic Robes of the Faculty of Medicine of the University of Munich—the first time that such an honor had been bestowed on a foreign physician.

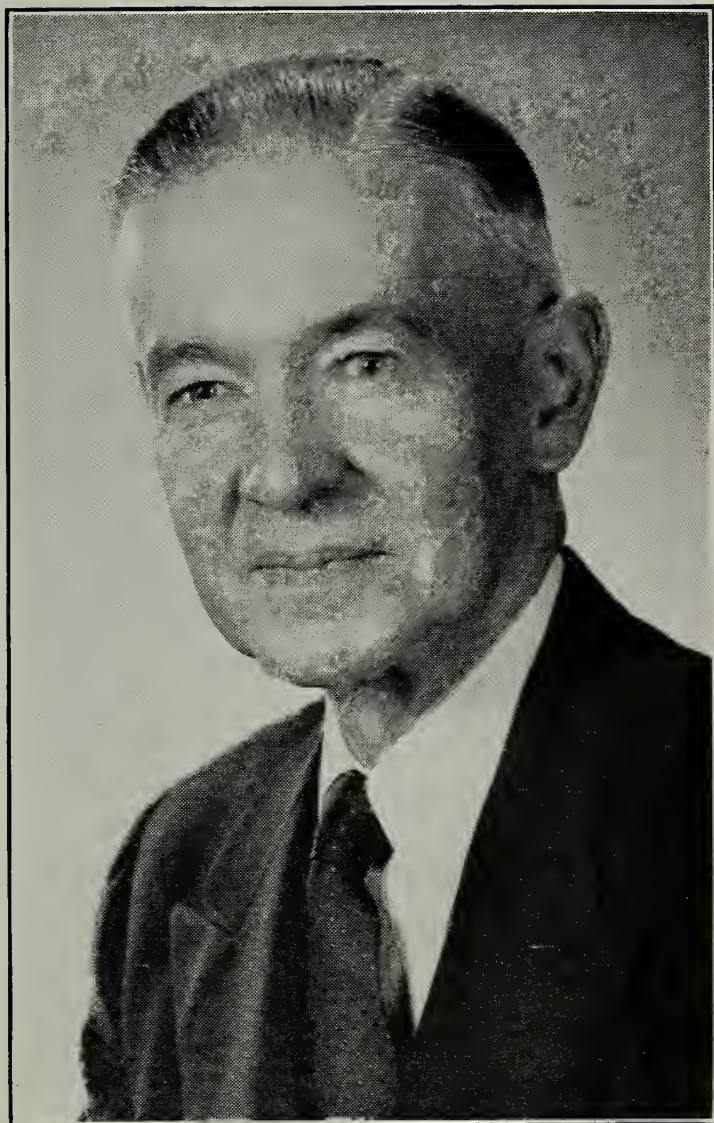
Dr. Meiling is a diplomate of the American Board of Obstetrics and Gynecology and a diplomate of the American Board of Preventive Medicine (Aviation Medicine), a Fellow of the American College of Surgeons and the American College of Obstetricians and Gynecologists. Among the numerous other organizations to which he belongs are the Aero Medical Association, World Medical Association, the Central Association of Obstetricians and Gynecologists and he holds honorary membership in the Royal Academy of Medicine at London, the Southeastern Surgical So-

ciety and the International College of Surgeons.

As early as 1932, Dr. Meiling was a cadet in the Army Air Force and a year before Pearl Harbor was in active service. In 1942 he was assigned to the staff of the Air Surgeon in the Army Air Force headquarters. Subsequent top echelon posts and responsibilities include the following: Chief of the plans division; air evacuation officer with responsibility of staff studies for transportation of casualties from zones of action; special assistant to the Air Surgeon; assistant surgeon of the 20th Air Force; chief of the morale division of the U.S. Strategic Bombing Survey in Europe. Decorations include the Legion of Merit and the Secretary of War Commendation Award. He holds the rank of Brigadier General in the Air Force Reserve.

In 1948 Dr. Meiling was appointed by the Secretary of Defense to the newly created Armed Forces Medical Advisory Committee and later was named assistant to the Secretary of Defense for Health Affairs. The purpose of this position was to unify administration and operation of the medical services of the Armed Forces. Following his tour of service in Washington he continued to serve as consultant to the Secretary of Defense for two years, and in addition has held a number of appointments in a medical advisory capacity to various governmental agencies.

Dr. Meiling's interest and participation in medical organization work and his acceptance of the appointment in Washington are closely allied. He left there assured that the basic policy of civilian control of military medicine had been established at Cabinet level. He has served four years as Treasurer of the Ohio State Medical Association, and in that capacity as a member of The Council. He also is a member of the governing council of the Columbus Academy of Medicine; has served the American Medical Association as a member and secretary of the Council on National Emergency Medical Service, and is currently a member of the Council on National Defense, chairman of



ROBERT S. MARTIN, M. D.

the Committee on Military Affairs and a member of the Committee on Federal Medical Service.

He has served several years as Alternate Delegate of the OSMA to the American Medical Association. He is a member of the State Association's Committee on Maternal Health, and, with Dr. Anthony Ruppertsberg, laid the groundwork for the task this committee is undertaking with a nine-year study and report on maternal mortality in Franklin County. He is also on the Association's Committee on National Defense and Committee on Veterans Affairs.

Dr. and Mrs. Meiling are the parents of one son, George R. L. Meiling.

THE PRESIDENT-ELECT

The House of Delegates chose as President-Elect Dr. Robert Scott Martin, Zanesville physician, and a member of The Council representing the Eighth Councilor District since 1952. Dr. Martin will succeed Dr. Meiling as President at

the close of the 1957 Annual Meeting in Columbus, May 14-16.

A native of Shelby County, Dr. Martin graduated from Sidney High School in 1912. He began his college work at Ohio Wesleyan University and continued it at the University of Cincinnati, receiving the B.S. degree. He was awarded the M.D. degree from the University of Cincinnati College of Medicine in 1919.

His internship training took him to the Creighton Memorial Hospital in Omaha, Nebraska, after which he remained in the west until 1930, engaging in general practice at Red Cloud, Nebraska. He then took graduate training at the New York Eye and Ear Infirmary and moved to Zanesville where he has specialized in eye, ear, nose and throat since 1931.

Dr. Martin is on the staffs of Bethesda Hospital and Good Samaritan Hospital in Zanesville. He is a member of the Board of Governors of the American College of Surgeons, being one of three members representing the Section on Otorhinolaryngology of the American Medical Association. He is also a member of the Columbus Ophthalmological and Otolaryngological Society.

In addition to his duties as a member of The Council of the Ohio State Medical Association, Dr. Martin has been chairman of the Association's Auditing and Appropriations Committee and a member of the Committee on Hospital Relations.

Active in civic and professional affairs in the Zanesville community, Dr. Martin is a former president of the Muskingum County Academy of Medicine, a past-president of the Rotary Club, vestryman in the Episcopal Church, and a trustee of the YMCA. In 1953 he was chairman of a campaign which raised \$1,500,000 for Good Samaritan Hospital.

Dr. Martin is Vice-President of the Board of Trustees of Muskingum College, New Concord, and a member of the Ohio Wesleyan Associates.

He is a member of Nu Sigma Nu, Phi Gamma Delta, various Masonic orders and the Elks Lodge.

Dr. and Mrs. Martin are the parents of

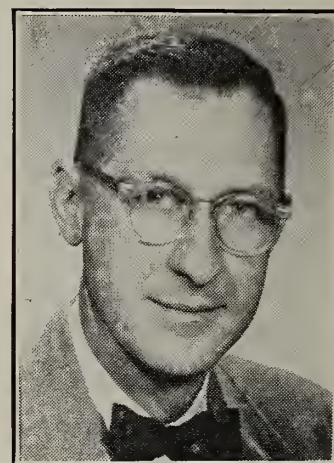
one daughter, Mrs. Donald B. Geiger, Cleveland.

EIGHTH DISTRICT COUNCILOR

The House of Delegates elected Dr. William Duane Monger, of Lancaster, to fill one year of the unexpired term of Dr. Martin, as Councilor of the Eighth District.

Dr. Monger has been a practicing physician in Lancaster since February of 1947 and in recent years has limited his practice to orthopedic and traumatic surgery.

He was born in Greenville, but as a child moved with his parents, the late Dr. John E. Monger and Mrs. Monger, to Columbus where he graduated from North High School. He received his B.A. degree from Ohio State University in 1938 and the M.D. degree in 1942 from OSU College of Medicine where he was a member of Nu Sigma Nu.



WM. D. MONGER, M.D.

Dr. Monger then took his internship and first year of surgical residency at Nashville General Hospital, at the same time instructing in the Department of Surgery at Vanderbilt University. From 1944 to 1947 he was in military service, where he served with an evacuation hospital in the European Theater as chief of a surgical team, attaining the rank of Captain. He has taken time out from practice to take graduate work at Harvard University, Cook County Hospital, Chicago, and St. Luke's Hospital in Cleveland where he had a year's fellowship in orthopedic and traumatic surgery.

Dr. Monger is this year's President of the Fairfield County Medical Society, where he has been active in organization work. He is a member of the surgical staffs of Lancaster-Fairfield County Hospital and Mt. St. Mary Hospital, Nelsonville; member of the Columbus and Ohio State Surgical Society and on the College of Surgeon's Trauma Committee.

An active participant in community organizations, he is past-president of the local Exchange Club. He is married and the father of six children.

NEW TREASURER

The House of Delegates elected Dr. Geo. J. Hamwi, Columbus, as Treasurer to fill two years of the unexpired term of Dr. Meiling. Dr. Hamwi is a practicing physician in Columbus, associate professor of medicine and head of the Division of Endocrinology and Metabolism in the Department of Medicine, OSU College of Medicine. He has written extensively in the field of endocrinology

and metabolism, being author or co-author of some 17 papers which have appeared in professional publications in the past five years.

Dr. Hamwi is a native of New York City and received his early education in that metropolis.



GEO. J. HAMWI, M. D.

He pursued his pre-medical education at Columbia University for three years and the fourth year at the American University of Beirut in Lebanon where he received the B.S. degree in 1936. He continued his studies at the American University of Beirut and in 1940 received the M.D. degree.

A year of internship followed at the Metropolitan Hospital in New York, and a second at the Presbyterian Hospital in Philadelphia. Then in 1942 Dr. Hamwi went into military service with the Navy and served until July of 1946 as a flight surgeon, attaining the rank of lieutenant commander.

Dr. Hamwi first came to Ohio State following his release from active duty in 1946, took a year of residency work in pathology and another as chief medical resident at St. Francis Hospital under the OSU graduate program. He returned to New York in 1948 and 1949 where he was a fellow in medicine in the Section on Endocrinology and Metabolism at Cornell University College of Medicine and New York Hospital.

He returned to Ohio State in 1950 and became assistant professor of medicine in the Division of Endocrinology and Metabolism and the following year was elevated to associate professor and head of the division.

He is a diplomate of the American Board of Internal Medicine and holds memberships in the following professional organizations: American Medical Association, American Federation of Clinical Research, New York Academy of Sciences, American Diabetic Association, Ohio Academy of Science, American Association for the Advancement of Science, American Geriatrics Society, Endocrine Society and the American College of Physicians of which he is a Fellow.

Dr. Hamwi is married and the father of three children.

PAST-PRESIDENT

Dr. Charles L. Hudson, Cleveland, as immediate Past-President, will continue to serve on The Council for another year.

COUNCILORS RE-ELECTED

The following Councilors were re-elected for additional two-year terms:

Dr. Charles T. Atkinson, Middletown, was re-

elected Councilor of the First District. Dr. Atkinson was first elected to that office in 1954.

Dr. James R. Jarvis, Van Wert, was re-elected Councilor of the Third District. He was first elected to that office in 1952 and re-elected in 1954.

Dr. George W. Petznick, Cleveland, was elected to his first full term as Councilor of the Fifth District. He was elected last year to fill the remaining year of the unexpired term of Dr. Hudson.

Dr. Robert E. Hopkins, Coshocton, was re-elected Councilor of the Seventh District. He was first elected to that office in 1954.

Dr. Carter L. Pitcher, Portsmouth, was re-elected Councilor of the Ninth District. He was elected to that office in 1953 to fill one year of an unexpired term and was elected to his first full term in 1954.

Dr. H. T. Pease, Wadsworth, was re-elected Councilor of the Eleventh District. Dr. Pease was first elected to that office in 1954.

Councilors in the midst of two-year terms are: Dr. George A. Woodhouse, Pleasant Hill, Second District; Dr. Paul F. Orr, Perrysburg, Fourth District; Dr. C. A. Gustafson, Youngstown, Sixth District, and Dr. Edwin H. Artman, Chillicothe, Tenth District.

World Medical Assembly Is Scheduled in Havana

The World Medical Association will hold the opening plenary session of its 10th General Assembly in Havana, Cuba, on October 10, which is Cuban Independence Day. This is the first time that an Assembly has been held in Latin America. The only other meeting held in the Western Hemisphere was the 1950 Assembly in New York City.

The '56 Assembly will begin with a day of registration on October 9 and sessions will continue through October 14. October 15 will be devoted to an excursion to Veradero Beach.

Toledo Doctors Take Part in Medico-Legal Institute

Several Toledo physicians participated in a Medico-Legal Institute sponsored by the Ohio State Bar Association as part of its annual meeting in Toledo, May 17-19. They and the subjects discussed were as follows:

Dr. Gordon M. Todd, "Trauma and Coronary Disease."

Dr. Edward J. McCormick, "Trauma and Cancer."

Dr. Fred B. Hawkins, "Trauma and Arthritis."

Dr. Bernard Steinberg, "How To Make the Best of the Medical Expert."

Dr. Joseph Duty, "Criteria of Insanity."

Dr. Nicholas Dallis, "Mental Competence."

Dr. Jack Schechter, "Traumatic Neuroses."

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¹Albertson, H.A. and Trout, H. H., Jr.: *Antibiotics Annual* 1954-55, Medical Encyclopedia, Inc., New York, N.Y., 1955, pp. 599-602.

²Prigot, A.; Whitaker, J. C.; Shidlovsky, B. A., and Marmell, M.: *ibid*, pp. 603-607.



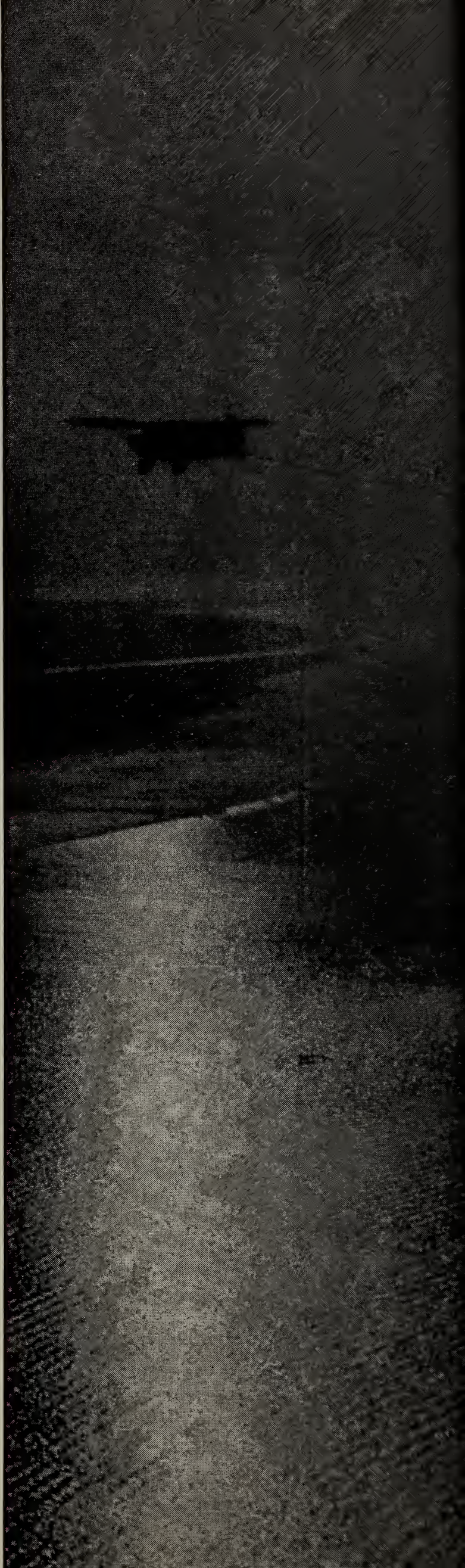
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ACHROMYCIN ACHROMYCIN

Address of the President . . .

Retiring Head of Association Makes Scholarly Address at First Session Of House of Delegates at 1956 Annual Meeting, April 10-12, Cleveland

By CHARLES L. HUDSON, M.D., Cleveland, Ohio

TO THE OFFICIAL FAMILY of the Ohio State Medical Association, greetings: One year ago, you, the members of the House of Delegates of the Ohio State Medical Association, did me the honor of electing me President-Elect of this Association. Coming to the presidency at that time was our colleague and friend, David W. Heusinkveld. You all know of his untimely death, almost before his administration could get under way. At once and with the first official business of The Council, I was precipitated into the presidency.

SUGGESTS DUES INCREASE

Almost a year has gone by and I find myself giving the President's Address.

I should like to begin by expressing my gratitude to all who have participated in the work of the Association this year. I must pay tribute first to the personnel of our headquarters office who, I know from firsthand knowledge, have handled a gigantic volume of business with amazing expertness and dispatch. If you have not seen, as I have, all that the Association does for its members and for the public through the headquarters office, these words will not have particular force. The Association's work is important and it is worthy. It must not be interrupted nor cut back. To keep the program going, Council is recommending an increase in dues. I hope that this proposal will receive your unanimous support.

COMMITTEES AND COUNCIL PRAISED

Second, to the members of committees who have spent many Sundays earnestly discussing the problems presented to them, I give my thanks. Next, to The Council whose serious and unselfish contributions of time and person, I give my deep appreciation. Finally, to you members of the House of Delegates who have likewise given of your time and interest, I give my gratitude.

THIS YEAR'S EXPERIENCES

Today, I ask your indulgence if I depart somewhat from the format of the President's address as it has been established by some of my predecessors. I will not relate our activities by committee or Council meetings. These events have been recorded in *The Journal*.

Instead, I would like to discuss a few general questions which we doctors have been confronted with during the past year and some of those

which we will have before us during the ensuing months.

My intent is not to tell you what to think but to show a line of reasoning which can be used, if you wish, to form an opinion about such problems.

First, I would like to talk about the question of institutional or corporate practice of medicine—a topic which has been the subject of much discussion and debate during the past year particularly.

THE PHYSICIAN IN SOCIETY

I would like to point out the essential features of this latter kind of practice and mention some of the forces which have brought the change about. I should like also to consider in some detail the ways we might look at this change. Finally, I would like to note that the unique position of the doctor in society must influence our judgment as we discuss the various approaches to the problem of institutional practice of medicine.

I need a name for this kind of medical practice; institutional (referring to an institution in its broadest sense) will have to suffice. This implies that medical care is being organized around some administrative regimen that can engage the services of doctors to provide medical care. Many kinds of institutions or administrative units are involved; government at all levels, the armed forces, the Veterans Administration industry, union and management plans; citizen cooperatives and prepayment medical care schemes of all descriptions.

The distinctive feature of this institutional practice is the interposition of an administrative arrangement between the doctor and the patient. The administrator on some occasions may influence the doctor and may possibly interfere with the doctor's judgment as to what might be in the patient's best interest. Interference does not always occur. In fact, instances of this type of practice may be found where good care results.

PUBLIC CONCERNED WITH HEALTH

I think it is pertinent to the discussion to observe at this point, that health is a "hot" subject, one of national as well as local interest. From the time of the surveys in the 30's on the cost, quantity and distribution of medical care, through the numerous attempts to pass health legislation in Washington (including the epitome of "socialized medicine," the national compulsory

health insurance bill) up to the present when we have health advisers at Cabinet level, health has been a national concern. Some laymen, while they have had respect for conventional practices of medicine, have thought that our system of medical practice was inadequate and that they had to make changes that they thought were needed. Offered as a substitute for Federal medicine was the organization of medical care at a local level and the support of local and voluntary health insurance projects instead of national and compulsory ones.

I picked the following from text in a local newspaper article: "Laymen began to make medical and surgical progress their business as well as (that of) the doctors'. They put their lay noses into the medical sanctum to find out what was going on . . ." The article also mentioned that they put their lay hands into their pockets to supply funds for investigation, to support schools and so forth. There is adequate evidence of expropriation by laymen of some degree of control of medical affairs; at the same time there has been acceptance, by laymen, of financial responsibility. Organization of medical care seems to be one of the by-products of the national interest in health, and good or bad, its existence must be recognized.

ORGANIZED PROGRAMS

With this brief narrative of the development of widespread interest in health matters, we may now approach the question of institutional practice of medicine. In my opinion, there are four ways to look at the question and for the sake of clarity of thought, the four should be considered separately: 1. The point of legality. 2. The point of ethics. 3. The question of interference with our professional freedom or with our right to make a living; and 4. An analysis of institutional practice as to its medical merit.

LEGAL ANGLES EXAMINED

First, the point of legality. In Ohio the corporate practice of medicine is illegal. This law was compiled presumably to protect the people's interest and any violation of this law is an affront to all the people. Consequently, in a settlement of a controversy regarding a violation of this law, it might be anticipated that the legal verdict would ultimately decide in favor of that position which most nearly represented the good of the whole, rather than for either contestant.

Although our Association on numerous occasions has issued statements opposing the corporate practice of medicine, even listing this or that type of practice as corporate practice, we must recognize that allegations of corporate practice must be verified by trial in court. Institutional practice (as I have defined it) and corporate practice are not necessarily synonymous. There are examples of institutional practice which are considered to be legal and hence not the corporate practice of medicine. The issue

must be settled on the facts of the alleged illegal practice.

ETHICAL CONSIDERATIONS

I am not unmindful that the persuasive force of law becomes attractive when efforts at conciliating opposing points of view seem to fail. But, I feel that in our role as physicians and guardians of the public health, we have the same objective as the law—namely the public good—and we can reach that objective whether by example or by persuasion while travelling on ground that is more familiar to us than the law.

Second, the point of ethics. Section 3 of Chapter VII of the Principles of Medical Ethics of the American Medical Association says: "Contract practice as applied to medicine means the practice of medicine under an agreement between a physician or a group of physicians, as principals or agents, and a corporation, organization, political subdivision or individual, whereby partial or full medical services are provided for a group or class of individuals on the basis of a fee schedule, or for a salary or for a fixed rate per capita.

"Contract practice *per se* is not unethical. Contract practice is unethical if it permits of features or conditions that are declared unethical in these Principles of Medical Ethics or if the contract or any of its provisions causes deterioration of the quality of medical services rendered."

GOOD OF THE PATIENT

It becomes clear by the wording of this last paragraph that hiring out is not in itself unethical and that if there are other considerations they are to be related to the facts particular to the situation. My interpretation of this point is that if the hiring caused harm to the patient or detriment to the quality of care provided the patient, it would be considered unethical on that ground. This is essentially my point number four to be considered in a moment.

ECONOMIC FACTORS

Third, the point of personal, professional and economic rights. Financial return to the doctor from his practice comes from several sources: fees from patients or insurance companies; from fee schedules established by collaboration between layman and doctor; or salaries from other doctors or organizations. A doctor's income is a personal affair depending on his abilities and his desires and at the moment there is no control over it except that which the consumer of doctors services ordinarily exerts. Engaging in institutional practice implies that the doctor accepts a salary or other financial arrangement which he enters into voluntarily.

At the moment we are free to use our medical training as we wish: practice not at all, practice alone or in groups, sharing expense or income or both; or take a salaried position.

Therefore, it might be said that the threat to our freedom in institutional practice is not

immediate or if it is, it is voluntarily accepted. Implied, however, is the threat that institutional practice may become so extensive that we who do not want it will be forced to accept it involuntarily. No amount of reassurance by institutions seems to quiet this very real fear.

If there be reason for this fear, should the doctor appeal on the grounds of loss of economic and professional freedom?

A PRICELESS QUALITY

This question leads, I think, to the fourth way to look at institutional practice: The question of its medical merit.

Here I would digress for a moment to make an analysis of our position in society. As I said earlier, I believe this appraisal helps one to judge such problems as institutional practice properly and dispassionately.

We doctors (not a large group in numbers) without our striving for it, have been placed by society in a position of privilege and responsibility. We have respect and sometimes worship, we are permitted to keep confidences, and we are excused from some of the onerous parts of citizenship. I do not need to tell you the extent of it.

A HERITAGE

This is no right or special entitlement of ours. It is not conferred on us like a degree at graduation. It is something we must earn but which also is given, in advance, to the newest of doctors in consideration of the services of doctors who have gone before.

Our strength and influence comes from the confidence and trust of those we serve. We can show our influence by demonstrating a greater competence or capacity to take care of the needs of the public in the ways we are expert.

When we approach such a problem as institutional practice from the point of legality or of threat to our personal freedom, we divest ourselves of distinctive standing and petition the public as citizens without special privilege. When we approach this problem from the point of medical merit, we keep our privileged position as doctors for we are then acting as we are expected to act in our special capacity.

A POSITIVE APPROACH

Weighing new proposals in medicine, judging their worth to the public and estimating their future effect on medical practice unselfishly is a sound and positive program, I believe. It is in keeping with the objectives of private practice. It would always have public support.

Another matter which has claimed the attention of medical societies and individual physicians during the past year is the so-called polio vaccine problem. This question has caused much confusion and many misunderstandings. No doubt a much better job would be done if the program could be started again. I do not intend to touch

on the details of this subject. The writing of a book would be required to do that.

My reason for bringing up the polio vaccine question is to emphasize that we must be cautious and judicial in the way we react to this and to other troublesome problems. In planning actions and in drafting public statements on the polio vaccine topic, we must keep in mind that this program has had a terrific impact on the public and that the public has a big stake in it. We must base our views relating to the use and distribution of the polio vaccine on the major premise of whether the procedures being followed are or are not in the public interest and of value to the people generally.

Also, may I add this observation: The program seems to have been carried on with less confusion and with fewer problems in those areas where there has been close liaison between the local medical society and the local public health department. Here we have another example of the need for and value of active and alert medical organization in all counties.

PUBLIC CONCERN IS NATIONAL

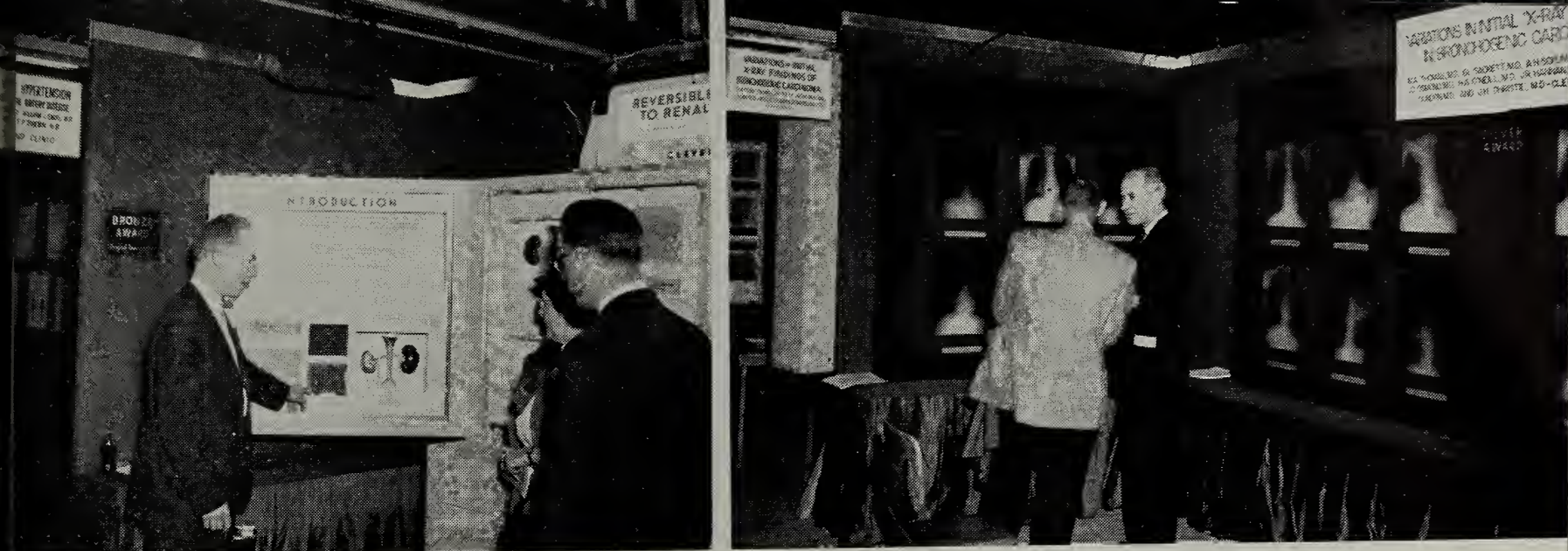
As I intimated previously, "health" is a subject of major national importance. The polio vaccine matter has added to the truth of that statement. That being the case, we as an organization and as individual physicians must give more attention year after year to the things going on in the Congress and in our own State Legislature. During the past year, our state and local legislative committees have met their responsibilities. Are physicians doing enough in this important field? I believe that as individuals not nearly enough physicians take the time and trouble to talk or write to our U.S. Senators, to their Congressman, state senator and local representative on medical and health proposals.

I talk about legislative activity for two reasons. First, in formulating our policies on health and medical issues and in contacting our legislators, we should keep in mind the general theme which I have kept emphasizing: Is it good or is it bad for the public? Unless we base our actions and opinions on that principle we will find ourselves in an untenable position.

Second, because this is an election year, physicians as individuals should—must—become active in political affairs. They must meet their obligation as citizens by working for and voting for the candidate believed to be the best qualified for the office he seeks. Our medical societies cannot assume this responsibility. They can provide us with information but electioneering, ringing doorbells, making financial contributions and helping to get out the voters are jobs which we as individual doctors must do.

EMPHASIS ON LOCAL ALTERNES

As a final point, let me again emphasize the importance of keeping our local medical societies up to par. The need for this is so apparent



Two of the award winning scientific exhibits: Left, the Cleveland Clinic team exhibit on reversible hypertension, Dr. E. F. Poutasse, explaining; and, right, the Silver Award winning exhibit on bronchogenic carcinoma. Dr. J. D. Osmond, Jr., one of the sponsoring teams, is shown in profile.

that there hardly seems to be any reason for mentioning it again. However, as I have viewed the situation from a place on The Council of the State Association, I have discovered that too many times a county society fails to act on a given subject until the damage has been done. Also, we find a society coming to the State Association with an appeal that it solve some local problem before the society has either given real study to the matter or has exhausted its efforts to find a solution. Most of our problems, arguments, controversies and misunderstandings within our own ranks or in our relations with others can be solved or dissipated through local conferences and actions. The state and national organizations stand ready to help but they should be called upon to solve local problems only after local efforts have proved unsuccessful.

OUR STRONGEST POSITION

In conclusion, let me repeat what I said in a talk last Fall at a conference of state and local officers of the Woman's Auxiliary to the Ohio State Medical Association with regard to what I believe our position should be in these changing times:

"Our strongest position, it would seem to me, would be to concentrate our attention on the existing quality of medical care and to be ever watchful of any changes which might result to the detriment of the quality of medical care. The public should be made aware that our interest is solely in their welfare; that we do not resist change because we are reactionary or because it threatens our personal privilege; that we do not accept change for newness-because-it-is-new but that we are ever vigilant in our special capacity to be critical and to understand what is best for the welfare of the public.

"I believe that the ideals and objectives of organized medicine have been unselfish and have been well intentioned. I think we should endeavor with careful direction and judicious explanation to show that we accept and help to direct the changing face of medical practice for the greater benefit of everyone concerned."

I do not ask that you accept my ideas. I

do ask that each of us form studied opinions. I am fearful of apathy and of the expectation that someone will keep our affairs in order during those intervals wherein the human mind is otherwise occupied.

Institute for Health Commissioners Scheduled in Granville

The Seventh Institute for Health Commissioners on the subject of industrial health will be held in the Granville Inn, Granville, June 26-28, Dr. Thomas F. Mancuso, chief of the Division of Industrial Hygiene of the Ohio Department of Health, announced.

Among physicians who will participate in the program are: Dr. H. S. Van Ordstrand, of the Cleveland Clinic, president of the Ohio Chapter of the American College of Chest Physicians and governor for Ohio of the American College of Chest Physicians; Dr. Donald J. Birmingham, chief dermatologist of the Occupational Health Program of the U. S. Public Health Service; Dr. Wilhelm C. Hueper, chief of the Environmental Cancer Section of the National Cancer Institute; Dr. Herbert Stokinger, chief toxicologist of the U. S. Public Health Service, and Dr. Simon Kinsman, associate chief of radiological health training of the U. S. Public Health Service.

Colleagues Honor Dr. Schriver At Testimonial Dinner

Approximately 300 colleagues and friends of Dr. L. Howard Schriver, Cincinnati, attended a testimonial dinner in his honor at the Losantiville Country Club, Cincinnati, April 26. James E. Stuart, Executive Vice-President, Hospital Care Corporation, Cincinnati, and Dr. Paul R. Hawley, Director, the American College of Surgeons, were the principal speakers. Dr. Sidney N. Mendelsohn, Cincinnati, presented Dr. Schriver with a leather-bound volume of many letters from physicians and patients expressing tribute to him for his more than 40 years as distinguished surgeon and teacher, and leader in the community, medical organization and Blue Shield.

Annual Meeting in Review . . .

Highlights and Side Lights of Happenings at the Cleveland Meeting And Some of the Events That Made It Successful With Picture Review

THE MANY personalities, activities and items of interest that go into making a successful Annual Meeting are too numerous to report in detail. These are only some of the highlights of such activities and supplement other phases of the meeting as reported in the accompanying articles.

GUEST SPEAKERS

The official program, listing more than 100 Ohio physicians who participated in the program, was published in the March issue of *The Journal*. The House of Delegates in a resolution expressed its appreciation for a job well done by all those who participated.

Out-of-state guest speakers who participated in the program were: Dr. Julian Johnson, Philadelphia, Pa.; Dr. Edgar Burns, New Orleans; Lt. Col. Curtis P. Artz, U. S. Army Medical Corps, stationed at Brooke Army Medical Center, Fort Sam Houston, Texas; Dr. D. E. Cameron, Montreal, Canada; Dr. Hermann Burian, Iowa City; Dr. Donald L. McRae, Montreal, Canada; Dr. Morton Marks, New York City; and Dr. Sylvester J. O'Connor, Ann Arbor, Mich. Dr. O'Connor spoke on the subject originally announced for Dr. Carl E. Badgley, of the same city, who was unable to be present. Additional out-of-state speakers were guests of Specialty Societies which met during or before the Annual Meeting.

OTHER GUESTS

The Association was honored by the presence of a number of representatives of neighboring associations and other organizations. Among them were Dr. N. Louis Bosworth, Lexington, Vice-President of the Kentucky State Medical Association, and Mrs. Bosworth; Mrs. Alfred W. Crozier, Pittsburgh, President-Elect of the Woman's Auxiliary to the Pennsylvania State Medical Association; Mrs. Mason G. Lawson, Little Rock, Ark., President of the Woman's Auxiliary to the AMA; Mrs. Delbert M. McGregor, Flint, and Mrs. A. C. Stander, Saginaw, President and President-Elect respectively of the Woman's Auxiliary of Michigan; Dr. Robert L. Shaeffer, Allentown, President of the Pennsylvania State Medical Association, and Mrs. Schaeffer; Mrs. Paul P. Warden, Grafton, President of the Woman's Auxiliary of West Virginia.

Bernard Boxerbaum, Ohio State medical student and representative of the Student AMA; David Miller who represented the Senior Class of

Western Reserve; and Robert Davies, of the University of Cincinnati Student AMA Chapter, were present as guests of the Association.

W. O. Rowland, Akron pharmacist, represented the Ohio State Pharmaceutical Association, with its Executive Secretary, James Merritt of Columbus. James A. Waggener, Executive Secretary of the Indiana State Medical Association, represented that organization.

THE COUNCIL

The Council met for a meeting and get-together dinner on Monday, the eve of the Annual Meeting. Also present were Past-Presidents of the Association, Delegates to the AMA and Annual Meeting committee chairmen and chairmen of many Association standing committees.

THE HOUSE OF DELEGATES

The House of Delegates met twice during the Annual Meeting, at which time representatives of Ohio's County Medical Societies as well as The Council came together to formulate the policies of the Association. The first meeting was held on Tuesday afternoon followed by dinner in the Euclid Ballroom of the Hotel Statler. The final meeting of the House followed luncheon on Thursday. Minutes of both meetings will be found in the official proceedings beginning on page 624.

An important function of the House of Delegates is election of Officers and Councilors. Results of this election will be found in the official proceedings while biographical sketches of newly elected officers and other information about The Council will be found beginning on page 608.

COMMITTEES APPOINTED

Important functions of the Association are carried out by standing and special committees which meet from time to time to deliberate on matters in their respective fields. By authority vested in him, President Meiling appointed additional members to the standing committees and members of the special committees. The roster of these committee members appears on page 558 of this issue.

SCIENTIFIC AND EDUCATIONAL EXHIBIT

An ideal setting for the Exhibits was provided in the spacious Main Arena of the Cleveland Public Auditorium, where the south end was devoted to the Scientific and Educational Exhibits and the opposite area to the Technical Exhibits. Many complimentary remarks were offered on the



Scenes at the 1956 Annual Meeting in Cleveland.

1. Gold Award Winning Exhibit of Dr. Ellison, Ohio State; shown are Dr. Richard J. Ireton, pointing, and R. H. Albertin, of Medical Illustration Service of OSU.

2. Dr. Hudson, left, hands the gavel to Incoming President Meiling before the House of Delegates.

3. Dr. Ernstene, left, chairman of the Committee on

Scientific Work, chats with Dr. F. C. Robbins, before start of the General Session talk on polio.

4. A Banquet Scene—one of the "official family" groups.

5. At the Banquet, Dr. Hudson, left, receives the Past-President's Button from Dr. Prugh.

6. Ray Bruner, right, medical writer for the Toledo Blade, interviews Dr. Saslaw, one of the program speakers.



A Certificate of Merit in the special exhibits category went to this display on aids for the heart patient sponsored by the Cleveland Health Museum, Dr. Bruno F. Gebhard, director.

work of the Committee on Scientific and Educational Exhibits headed by Dr. Arthur D. Nichol.

A special committee was appointed by The Council to judge the Scientific and Educational Exhibits and to offer appropriate recognition for outstanding displays. Selections were made in the fields of teaching, the original investigation field, and in the special exhibits category. Those selected are the following:

Gold Award in Teaching Field—The exhibit "Common Orthopedic Problems in Children," sponsored by Drs. Barry A. Friedman and Earl E. Smith, Mt. Sinai Hospital, Cleveland.

Gold Award in Original Investigation Field—The exhibit "The Ulcerogenic Tumor of the Pancreas," sponsored by Dr. Edwin H. Ellison, Ohio State University College of Medicine.

Silver Award in Teaching Field—The exhibit, "Variations in Initial X-Ray Findings of Bronchogenic Carcinoma," sponsored by the following Cleveland physicians: Drs. Merthyn A. Thomas, George L. Sackett, Arthur H. Schumacher, John D. Osmond, Jr., Hugh A. O'Neill, John R. Hannan, Carroll C. Dundon and James H. Christie.

Silver Award in Original Investigation Field—The exhibit, "Special Cardiopulmonary Techniques: Temporary Unilateral Pulmonary Artery Occlusion and Intracardiac Angiography," sponsored by Drs. Bernard L. Brofman, Bernard L. Charms and John C. Elder, of Cleveland.

Bronze Award in Teaching Field—The Exhibit, "Technique of Venipuncture in Infants," sponsored by Drs. Henry F. Saunders, Felino V. Barnes and Richard A. Bloomfield, of Mt. Sinai Hospital, Cleveland.

Bronze Award in Field of Original Investigation—The Exhibit, "Reversible Hypertension Due to Renal Artery Disease," sponsored by Drs. E. F. Poutasse, William J. Engle and Harriet P. Dustan, of the Cleveland Clinic.

Certificate of Merit in the Special Exhibit Category—This special award was given to the exhibit sponsored by Dr. Bruno G. Gebhard, director of the Cleveland Health Museum, Dr. Mieczyslaw Peszczyński and Dr. Nadene Coyne. The exhibit entitled "Able To Live Again," contained a life-size kitchen and other aids designed for heart patients.

THE TECHNICAL EXHIBIT

Nearly a hundred pharmaceutical firms and other organizations devoted to supply the medical profession were represented in the Technical Exhibit which was housed also in the Main Arena of the Auditorium. This proved a popular place for physicians who were able to chat at leisure with detail men about the latest developments in the various supply fields.

THE BANQUET

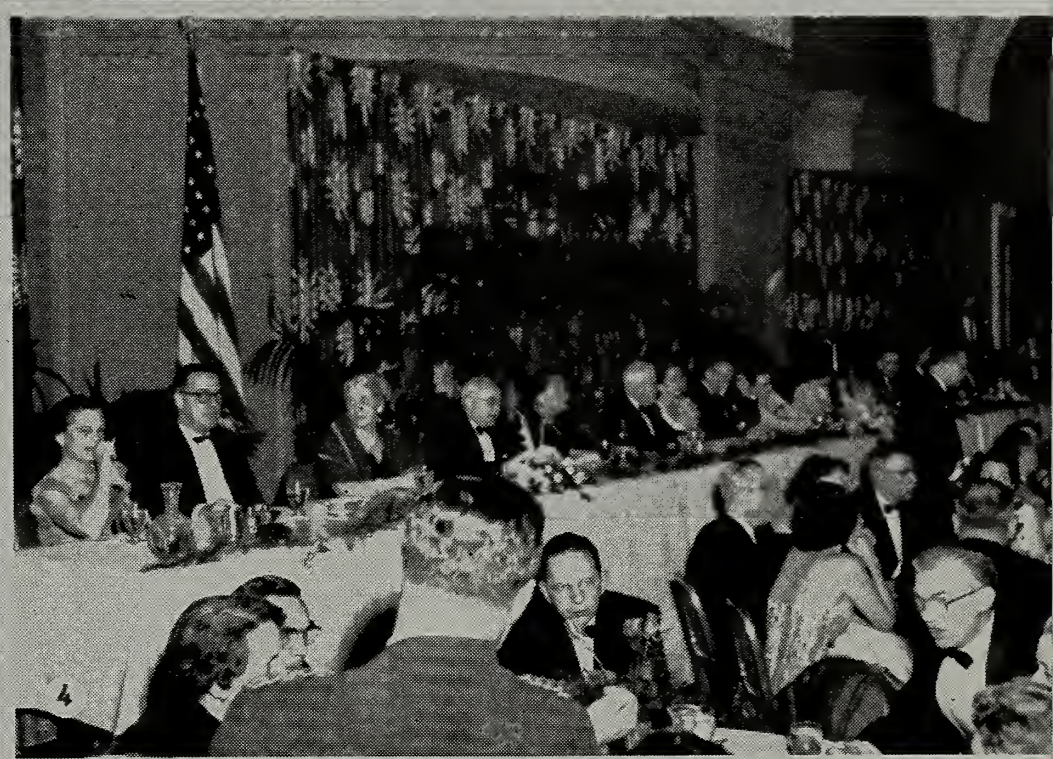
More than 400 members, their wives and guests enjoyed The Annual Banquet on Wednesday evening in the Grand Ballroom of the Hotel Statler. Following dinner, the audience was entertained with a humorous address on public relations by Dr. Russell B. Roth, of Erie, Pa.

Ballroom dancing to the music of Ray Eberle and his orchestra climaxed the evening's entertainment. See accompanying picture layouts for camera scenes at the Banquet.

PUBLIC RELATIONS

The public is keenly interested in what its doctors are doing, according to the interest shown in the Annual Meeting by the public press. Literally hundreds of newspaper clippings, reporting various phases of the Annual Meeting and physicians who took part, have come into the headquarters office during and after the meeting.

In line with this interest, the Public Relations Department of the State Association maintained close liaison with the public press. Information of



Camera highlights of the 1956 Annual Meeting in Cleveland.

1. Dr. Martin, right, new President-Elect, is congratulated by Dr. Hudson at the House of Delegates meeting.
2. A scene at the House of Delegates session.
3. Ohio Medical Indemnity's Exhibit proclaims the "Over Two Million Mark."
4. Scene at the picturesque Banquet Hall in the Hotel Statler.
5. A group of officials and guests at the Banquet.
6. Silver Award Winning Exhibit on Cardiopulmonary Techniques. Dr. Elder, right, is one of the sponsors.
7. The Registration Desk was a busy place.



public interest was relayed to newspapers, press associations, radio and television stations.

Medical writers from Cleveland and Toledo personally covered the scientific meetings and other activities of the Annual Meeting. Medical writers present were: Ray Bruner, *Toledo Blade*; Don Dunham, *Cleveland Press*; Josephine Robertson, *Cleveland Plain Dealer*; and Severino P. Severino, *Cleveland News*.

COMMITTEES

Working behind the scenes before and during the Annual Meeting were numerous committee members who were largely responsible for the success of the many program features and other activities.

The Committee on Scientific Work, whose members were responsible for planning and staging the Annual Meeting under direction of The Council, worked for almost a year on preparations. The Committee was composed of the following: Dr. A. Carlton Ernstene, chairman; Drs. William F. Ashe, Columbus; Louis G. Herrmann, Cincinnati; Thomas E. Rardin, Columbus; and Maurice A. Schnitker, Toledo.

The Committee on Scientific and Educational Exhibits was headed by Dr. Arthur D. Nichol, of Cleveland. Dr. Max Miller, Cleveland, was chairman of the Committee for Motion Pictures.

The Cleveland Committee on Arrangements was headed by Dr. George W. Petznick, Fifth District Councilor. Chairman of the Reception Committee was Dr. Charles S. Higley, while Dr. William L. Huffman, headed the Committee on Halls and Meeting Places.

WOMAN'S AUXILIARY

The Woman's Auxiliary to the Ohio State Medical Association met for its annual meeting at the same time as the Association meeting.

Mrs. William H. Evans, Youngstown, assumed the office as president, succeeding Mrs. Karl Ritter, Lima, who continues to serve as past-president.

Other offices elected are: Mrs. V. R. Frederick, Urbana, president-elect; Mrs. C. H. Bell, Mansfield; Mrs. W. R. Gibson, Oak Harbor, and Mrs. C. A. Colombi, first, second and third vice-president, respectively; Mrs. Lester W. Sontag, Yellow Springs, recording secretary; Mrs. Earl Young, Youngstown, corresponding secretary; Mrs. Herbert Van Epps, Dover, treasurer.

Mrs. Carl F. Goll, 1001 Granard Parkway, Steubenville, is the new chairman of the publicity committee.

Cincinnati—Dr. David G. Freiman has resigned his position on the faculty of the University of Cincinnati College of Medicine to accept a post as pathologist-in-chief and director of laboratories at Beth Israel Hospital in Boston and clinical professor of pathology at Harvard.

Commission Urges Change In Veterans' Benefits

A presidential commission's report on veterans' pensions that also goes into the subject of non-service connected medical benefits is stirring up another controversy.

The President's Commission on Veterans Pensions, headed by Gen. Omar Bradley, World War II leader and postwar Veterans Administrator, conducted a study covering more than a year in time and a wide range of subjects. It produced a 415-page report and a total of 70 recommendations.

The seven-man commission's report has the basic premise that military service in time of war or peace should be treated as discharging an obligation of citizenship and not of itself as a basis for future government benefits.

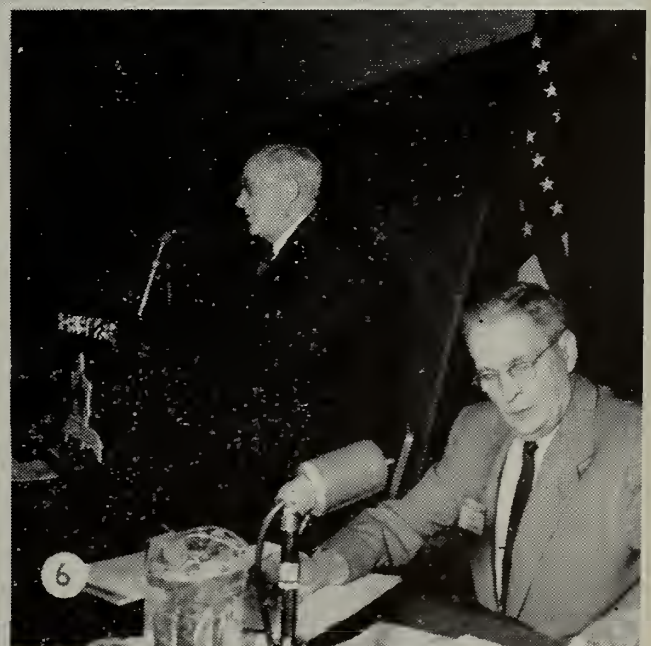
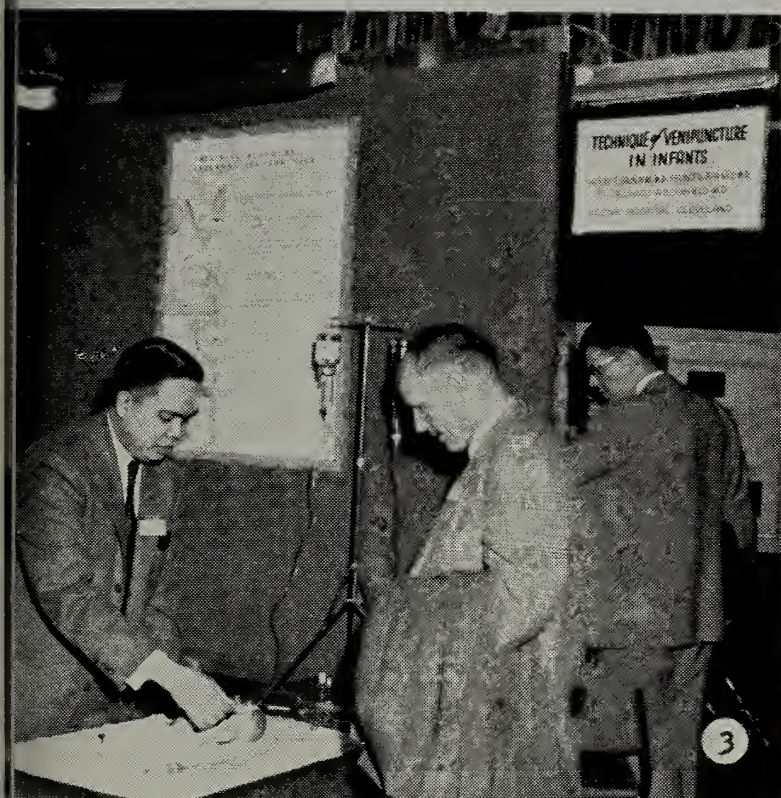
The commission made this additional point: "... under conditions of modern technology and warfare, the national defense might be served equally well by a civilian in a scientific laboratory or a war plant as by a uniformed serviceman—and in view of total war and atomic weapons, perhaps with greater personal hazard to the civilian. This further suggests that the special needs that veterans have because of military service should not be confused with the needs that all citizens have in common for such things as education, health services and economic security."

With this in mind, the commission proposes the gradual elimination of non-service connected benefits and observes: "Their justification is weak and their basic philosophy is backward looking rather than constructive." Such benefits, it adds, should be limited to a minimum level and retained only as a reserve line for veterans who fail to qualify for basic protection under Old Age and Survivors Insurance (Social Security).

The commission then goes one step further by recommending an end to the present automatic "presumption of service-connection" procedure. Now, presumption of service connection is automatic and mandatory for certain diseases if the condition is diagnosed within a specific period of time following discharge. Instead, the commission would substitute medical determination for chronic and tropical diseases, psychoses, tuberculosis and multiple sclerosis, with each case decided on its own merits.

Other recommendations: (1) increased reliance on the OASI system for certain veterans benefits, (2) prompt counseling of all veterans placed on compensation rolls as to VA and federal-state rehabilitation programs, and (3) requirement of reasonable medical or surgical treatment before payment of compensation.

Troy—Dr. Frank Schrader was named Troy's Young Man of the Year at the Junior Chamber of Commerce annual dinner meeting.



Additional Scenes at the 1956 Annual Meeting.

1. Dr. Budd, chairman of the important Resolutions Committee of the House.
2. One of the "official family" groups at the Banquet.
3. Dr. F. V. Barnes, left, demonstrates at the Bronze Award winning exhibit on venipuncture techniques.

4. Another of the "official family" groups. And a good time was had by all.

5. The House of Delegates in session.

6. At the rostrum, Dr. R. L. Shaeffer, President of the Pennsylvania State Medical Association. Seated, Executive Secretary Nelson.

House of Delegates . . .

Eighteen Complex Resolutions Disposed Of at Record-Breaking Meeting Of Association in Cleveland; Dr. Meiling Named President for Year 1956

MINUTES OF FIRST SESSION

THE first session of the House of Delegates of the 1956 Annual Meeting of the Ohio State Medical Association, April 10-12, was held in the Pine Room, Hotel Statler, Cleveland, Tuesday afternoon, April 10, at 5 o'clock.

The meeting was called to order by Dr. William J. Engel, President of the Cleveland Academy of Medicine, who, after welcoming the delegates, introduced the President, Dr. Charles L. Hudson, Cleveland.

Dr. Hudson then presented his presidential address. (See pages 614-617 in this issue for Dr. Hudson's address.)

MEMORIAL FOR DR. HEUSINKVELD

At the conclusion of his address, Dr. Hudson requested the House of Delegates to stand in silence in honor of the memory of the late Dr. David W. Heusinkveld, Cincinnati, who died in June, 1955, while serving as President of the Association. Then, Dr. Hudson called Mrs. Heusinkveld to the rostrum and he presented her with one of the Association's gold Past-President emblems in memory of Dr. Heusinkveld.

GUESTS INTRODUCED

Before starting the official business Dr. Hudson introduced the following guests to the House of Delegates: Dr. Robert L. Schaeffer, Allentown, Pennsylvania, President of the Pennsylvania State Medical Association, who addressed the House of Delegates briefly; the official representative of the Ohio State Pharmaceutical Association, Mr. W. O. Rowland, Akron, chairman of that association's Committee on Professional Relations, who made a talk on the relationship between physicians and pharmacists; Mr. James Merritt, Columbus, Executive Secretary of the Ohio State Pharmaceutical Association; Mr. Bernard Boxerbaum, Cleveland, official representative of the Ohio State University College of Medicine Student AMA Chapter; and Mr. David Miller, Cleveland, representing the senior class of Western Reserve University School of Medicine.

On motion duly made, seconded and carried, the minutes of the meetings of the House of Delegates held at the 1955 Annual Meeting in Cincinnati were approved as published in *The Ohio State Medical Journal*.

REFERENCE COMMITTEES

President Hudson then appointed the following reference committees:

Credentials of Delegates—Ralph W. Holmes,

Chillicothe, chairman; Benjamin S. Park, Painesville; Herbert D. Chamberlain, McArthur.

President's Address—Ray M. Turner, Springfield; George A. Boon, Oak Harbor; R. E. Tschantz, Canton; A. C. Ormond, Zanesville.

Resolutions—John H. Budd, Cleveland, chairman; J. Robert Hudson, Cincinnati; R. Dean Doolley, Dayton; Floyd M. Elliott, Ada; F. F. A. Rawling, Toledo; John A. Fraser, East Liverpool; B. C. Diefenbach, Martins Ferry; C. P. Swett, Lancaster; George N. Spears, Ironton; Charles W. Pavey, Columbus; N. P. Stauffer, Millersburg.

Tellers and Judges of Election—E. J. Meckstroth, Sandusky, chairman; Milo B. Rice, Pandora; Paul J. Schildt, Cleveland; Donald I. Minnig, Akron; Carl F. Goll, Steubenville.

Reporting for the Committee on Credentials, Dr. Ralph W. Holmes, Chillicothe, announced that 110 delegates and 13 officers and members of The Council, a total of 123, had qualified for participation in the proceedings of the first session.

NOMINATING COMMITTEE CHOSEN

The following were nominated and elected to the Nominating Committee:

First District—Harry K. Hines, Cincinnati, temporary chairman.

Second District—Maurice M. Kane, Greenville.

Third District—C. W. Berry, Wapakoneta.

Fourth District—Frank F. A. Rawling, Toledo.

Fifth District—H. A. Haller, Cleveland.

Sixth District—Donald I. Minnig, Akron.

Seventh District—J. W. Hamilton, Dover.

Eighth District—James A. L. Toland, Cambridge.

Ninth District—A. R. Hambrick, Wellston.

Tenth District—Ralph W. Holmes, Chillicothe.

Eleventh District—Russell H. Barnes, Mansfield.

RESOLUTIONS INTRODUCED

Dr. Hudson then called for the introduction of resolutions. Eighteen resolutions were presented and automatically referred to the Reference Committee on Resolutions. (See minutes of Second Session of the House of Delegates for text of resolutions as introduced and actions thereon.)

NEW BUSINESS

Under new business the House of Delegates authorized the issuance to the Belmont County Medical Society and the Drake County Medical

Society of copies of their charters, as previously recommended by The Council.

Following announcements regarding the annual meeting program, the House of Delegates then recessed for dinner, to meet again on Thursday afternoon, April 12, for a second and final business session.

MINUTES OF SECOND SESSION

The second and final session of the House of Delegates at the 1956 Annual Meeting of the Ohio State Medical Association was held Thursday afternoon, April 12, following a luncheon in the Ohio Room, Hotel Statler, Cleveland.

The chairman of the Committee on Credentials, Dr. Ralph W. Holmes, Chillicothe, advised the President that 115 delegates and 13 officers and members of The Council, a total of 128, had qualified for participation in the proceedings of the second session.

REPORT ON PRESIDENT'S ADDRESS

President Hudson then called for the report of the Reference Committee on President's Address. The report, reading as follows, was presented on behalf of the committee by Dr. Ray M. Turner, Springfield, committee chairman:

"The Committee on the President's Address wishes to commend Doctor Hudson on behalf of our committee, the House of Delegates, and the members of the Ohio State Medical Association on his splendid address at the first session of the House.

"Doctor Hudson was hurried into the presidency by the untimely death of Doctor Heusinkveld and is to be complimented on his fine record in office under unusual circumstances.

"In lieu of detailing the many activities of the Headquarters Staff and Council, Doctor Hudson has referred us to the printed record and expressed his gratitude to all participants.

"His address has been both enlightening and thought-provoking in asking and answering some of the questions relevant to the influences affecting medical practice today. In this he has reviewed some of the known facts and thrown light on the present and future problems concerning the institutional practice of medicine.

"Doctor Hudson has outlined a strong course to follow in which he cautions all of us to be mindful of our position in society as one to be earned, then proceed well informed and active, individually, and in our county societies to solve our own problems, keeping always in mind the best interest of the public.

"Finally, Doctor Hudson reminds us that we are not only doctors but citizens as well and as such should fulfill our civic and political obligations."

On motion duly made, seconded and carried, the report of the Reference Committee on President's Address was approved.

GUESTS INTRODUCED

At this point Dr. Hudson introduced to the House of Delegates Dr. Russell B. Roth, Erie, Pennsylvania, former president of his local medical society, who had been a guest speaker at the Annual Banquet on Wednesday evening; Mr.

James A. Waggener, Indianapolis, Indiana, Executive Secretary of the Indiana State Medical Association; and Mr. Robert Davies, Cincinnati, official representative of the University of Cincinnati College of Medicine, Student AMA Chapter.

ACTION ON RESOLUTIONS

Dr. John H. Budd, Cleveland, chairman of the Committee on Resolutions, then took the platform and presented the report of his committee. Copies of the original resolutions and copies of the Reference Committee Report were distributed to members of the House of Delegates.

Following is the text of each resolution, as introduced, and the recommendations of the Committee on Resolutions pertaining to each resolution:

RESOLUTION L

Resolution L was introduced by Dr. J. Martin Byers, Greenfield. It read as follows:

WHEREAS, One section of H. R. 7225 now pending in the Finance Committee of the United States Senate would provide cash payments under the Social Security System to persons who have attained the age of 50 and who have been certified as totally and permanently disabled, and

WHEREAS, The enactment of the above provision has been opposed by the House of Delegates of the American Medical Association in session in Boston in December, 1955; by The Council of the Ohio State Medical Association at its meeting on December 10, 1955; by distinguished physicians and others with long years of experience in disability and rehabilitation programs and by representatives of the insurance industry, in testimony before the Senate Finance Committee, and

WHEREAS, Among those who testified in opposition to the disability payment section of H. R. 7225 was the Hon. M. B. Folsom, Secretary of the Department of Health, Education and Welfare, and regarded as the official spokesman of the Eisenhower Administration on this measure, and

WHEREAS, The following valid arguments have been made against the enactment of this proposal:

1. A non-partisan, objective and thorough study of the long-range implications of the entire Social Security Program should be undertaken before major amendments to the Social Security Act, such as the one referred to above, are considered.

2. Until more specific information is obtained on the whole field of disability and rehabilitation, medical reasons alone would appear to make the proposed program virtually impossible to administer—a point emphasized in testimony presented by many of the specialists who appeared before the Senate committee.

3. There is no known way to estimate the number of ill or handicapped persons who would qualify, so the cost cannot be calculated.

4. Proponents admit that the age deadline of 50 years is just a starting point and infer that eventually persons of all ages will be covered.

5. Enactment of an extensive program of disability payments for persons of all ages, including benefits for temporary disability, would broaden the Federal-State rehabilitation services

into a comprehensive Federal medical care program with treatment furnished by U. S.-employed physicians.

6. This proposal is not the real answer to the problems of the disabled and handicapped who need assistance, the real answer being well-financed and aggressively undertaken rehabilitation programs under the direction of state and local agencies, assisted financially in certain instances by the Federal Government, from which the handicapped will benefit far more than through cash assistance.

THEREFORE, BE IT RESOLVED, That the House of Delegates of the Ohio State Medical Association in session April 10, 11 and 12, 1956, in Cleveland, Ohio, confirms and endorses the actions taken by the American Medical Association and The Council of this association, opposing the enactment of the cash payments for disability provisions of H. R. 7225, and

BE IT FURTHER RESOLVED, That a copy of this resolution be transmitted to Ohio's United States Senators and members of the House of Representatives of the Congress, accompanied by a request that they give the sentiments and policies expressed herein careful consideration.

Resolution L, which confirms and endorses actions of the AMA and The Council of this association, opposing the enactment of the cash payments for disability provisions of H. R. 7225 pending in the U. S. Senate, was amended by the committee by inserting the words "these programs to be" between the words "agencies," and "assisted" in the sixth line of Paragraph No. 6 and then approved.

On motion by Dr. Budd, seconded and carried, the committee's recommendation approving Resolution L as amended was adopted.

RESOLUTION I

Resolution I was introduced by Dr. William A. Moore, Cincinnati. It read as follows:

WHEREAS, The cost of conducting medical practice has increased substantially over the past several years, and

WHEREAS, Certain areas of the Industrial Commission of Ohio fee schedule have not been increased accordingly, and

WHEREAS, The Industrial Commission Committee of the Ohio State Medical Association spent a long period in formulating recommendations for increases in the Industrial Commission of Ohio fee schedule, and

WHEREAS, The Industrial Commission of Ohio took an unusually long period of time in considering these recommendations and finally accepting only a low percentage of these increases, and

WHEREAS, According to past experience, any attempt to further increase the Industrial Commission of Ohio fee schedule will undoubtedly take a long period of time,

BE IT RESOLVED, That the Industrial Commission Committee of the Ohio State Medical Association proceed immediately on further requests to the Industrial Commission of Ohio for increases in certain important areas of the Industrial Commission of Ohio Fee Schedule.

Resolution I, pertaining to increases in the Workmen's Compensation Fee Schedule, was re-drafted by the committee. The substitute res-

olution which the committee recommended be adopted, read as follows:

SUBSTITUTE RESOLUTION I

"WHEREAS, The cost of conducting medical practice has increased substantially over the past several years, and

"WHEREAS, Certain items of the medical and surgical fee schedule of the Bureau of Workmen's Compensation are inadequate,

"THEREFORE BE IT RESOLVED, That the Committee on Industrial Health and Workmen's Compensation of the Ohio State Medical Association proceed immediately to submit to the Bureau of Workmen's Compensation recommendations for increases in certain important areas of the Workmen's Compensation Medical and Surgical Fee Schedule."

On motion by Dr. Budd, seconded and carried, the recommendation of the committee, that Substitute Resolution I be adopted, was approved.

RESOLUTION O

Resolution O, dealing with the subject of health agency fund drives, was introduced by Dr. T. L. Light, Dayton. It read as follows:

WHEREAS, More and more health agencies are being formed to attract voluntary funds to be used in fighting specific diseases, causing a duplication of manpower and overhead with a resultant needless waste of money and

WHEREAS, Several currently operating agencies, basing goals on estimated maximum funds available instead of actual need, are so successful through promotion by scare appeals, labeled as Public Education, that they have surplus funds with which they encourage hastily formed and ill conceived projects; and

WHEREAS, The continued success of individual fund raising drives is contingent upon an ever increasing annual goal in spite of a fluctuating, static or decreasing need; and

WHEREAS, The best interests of mankind as a whole being, and not a collection of special diseases, might be effected through a coordinated appeal for health funds and a coordinated dispersal of those funds; therefore

RESOLVED, That the Ohio State Medical Association adopt as its policy the achievement of a single health fund campaign, the funds of which will be allocated to health agencies in accordance with needs and projects that best serve the interests of all peoples; and

RESOLVED, That a committee be appointed by the Ohio State Medical Association to gather facts and experiences to be disseminated to County Society memberships to aid in the formulation of a County Society policy that is best able to achieve such interests.

SUBSTITUTE RESOLUTION O

The reference committee presented a substitute resolution reading as follows and recommended approval of the substitute resolution:

"WHEREAS, More and more health agencies are being formed to attract voluntary funds to be used in fighting specific diseases, causing a duplication of manpower and overhead with a resultant needless waste of money; and

"WHEREAS, Several currently operating agencies, basing goals on estimated maximum funds available instead of actual need, are so successful through promotion by scare appeals, labeled as Public Education, that they have surplus

funds with which they encourage hastily formed and ill conceived projects; and

"WHEREAS, The continued success of individual fund raising drives is contingent upon an ever increasing annual goal in spite of a fluctuating, static or decreasing need; and

"WHEREAS, The best interests of mankind as a whole being, and not a collection of special diseases, might be effected through a coordinated appeal for health funds and a coordinated dispersal of those funds; therefore

"BE IT RESOLVED, That the Ohio State Medical Association recommends that consideration be given to the formation of a single health fund campaign by the various communities in Ohio, the funds of which will be allocated to health agencies in accordance with needs and projects that best serve the interests of all people; and;

"BE IT RESOLVED, That a committee be appointed by the Ohio State Medical Association to gather facts and experiences on this subject which will be made available to County Medical Societies giving consideration to this question."

The motion by Dr. Budd to approve the committee's recommendation, which was seconded, was discussed by many on the floor. Following a series of motions which were adopted, the resolution was amended and finally approved by the House as follows:

AMENDED SUBSTITUTE RESOLUTION O

"WHEREAS, More and more health agencies are being formed to attract voluntary funds to be used in fighting specific diseases, causing a duplication of manpower and overhead.

"BE IT RESOLVED, That a committee be appointed by the Ohio State Medical Association to gather facts and experiences on this subject which will be made available to County Medical Societies giving consideration to this question."

RESOLUTION K

Resolution K was introduced by Dr. C. R. Jablonoski, Cleveland. It read as follows:

WHEREAS, The medical profession is vitally concerned with medical practice in hospitals controlled by governing boards constituted exclusively of non-physicians and

WHEREAS, Conflicts concerning proper patient care frequently arise as a result of failure of the governing boards to have readily available competent counsel from board members representing the medical staff and

WHEREAS, Many reasons which heretofore were used to exclude physicians from the governing boards are no longer tenable nor accepted and

WHEREAS, The American Medical Association and the American Hospital Association recommend that members of the medical staff be members of the hospital governing boards and

WHEREAS, Physicians properly elected by the staff to the hospital board with full responsibility and vote would be able to contribute much to the effectiveness of such a policy-making body,

THEREFORE BE IT RESOLVED, That the House of Delegates of the Ohio State Medical Association in session April 10 and 12, 1956, in Cleveland, Ohio, reaffirm the policies thus far expressed by the American Medical Association advocating medical staff representation on hospital governing boards, and

BE IT FURTHER RESOLVED, That the County Medical Societies of the State of Ohio

assume the responsibility to initiate the necessary procedure to inform the hospitals of this action and pursue its realization.

The committee rewrote this resolution for the purpose of clarity as follows:

SUBSTITUTE RESOLUTION K

WHEREAS, Delivery of the best possible medical care to patients is the joint purpose of the medical staff, the governing board, and the administrator of a hospital, and

WHEREAS, The attainment of this objective depends to a large extent on making it possible for the representatives of the medical staff to have free and direct access to the governing board, and

WHEREAS, One of the methods recommended by the American Medical Association and the American Hospital Association to accomplish the above is to provide for the election of representatives of the medical staff to membership on the hospital governing board,

THEREFORE, BE IT RESOLVED, That the House of Delegates of the Ohio State Medical Association in session April 10-12, 1956, in Cleveland, Ohio, endorses this recommendation and suggests to County Medical Societies that they inform hospitals in their communities of this action and urge such hospitals to take the proper steps to carry out this recommendation.

On motion by Dr. Budd, seconded and carried, the recommendation of the committee, that Substitute Resolution K be adopted, was approved.

RESOLUTION M

Resolution M was introduced by Dr. F. L. Browning, Cleveland. It read as follows:

WHEREAS, The physicians of the State of Ohio are paying a premium on malpractice insurance based on a national claim experience and

WHEREAS, The claim experience in the State of Ohio is markedly better than on the national level and

WHEREAS, There are insurance companies willing to write malpractice insurance on the state level and with better coverage than that provided at present therefore let it be resolved

That the Ohio State Medical Association be urged to take the necessary steps to investigate this problem and endeavor to make such Malpractice Insurance available to the physicians of the State of Ohio as quickly as possible.

The committee's report made the following comments on this resolution:

"As the House of Delegates knows, The Council of this Association already has begun a study of the malpractice insurance question, including the collection of data from all counties in Ohio relating to malpractice incidence, as directed by the House of Delegates at the 1955 Annual Meeting.

"Also, as many of you know, the Legal Department of the American Medical Association recently began a comprehensive nationwide study of the malpractice insurance problem, the results of which are being made available to all state medical societies from time to time.

"Therefore, we recommend that this resolution be referred to The Council and that The Council

be hereby directed to consider the suggestions contained in the resolution in connection with its study of the malpractice insurance question in Ohio."

On motion by Dr. Budd, seconded and carried, the recommendation of the committee on Resolution M was adopted.

RESOLUTION Q

Resolution Q was introduced by Dr. Charles W. Pavey, Columbus. It read as follows:

WHEREAS, There continues to be legislation submitted to Congress for the purpose of further socializing our economy and especially the practice of medicine; and

WHEREAS, Indoctrination with the philosophy of Socialism is still widely practiced in both our secondary schools and colleges; and

WHEREAS, The Essay Contest of the Association of American Physicians and Surgeons is one effective method of resisting this indoctrination which is inimical to the economic welfare of our whole country and to the best method of providing medical care for its citizens;

THEREFORE BE IT RESOLVED, That the Ohio State Medical Association reaffirm its previous endorsement of the Essay Contest of the Association of American Physicians and Surgeons (Titles: The Advantages of Private Medical Care or the Advantages of the American Free Enterprise System); and

BE IT FURTHER RESOLVED, That this contest be recommended to the Ladies Auxiliary of the Ohio State Medical Association for sponsorship.

The committee made the following recommendations regarding Resolution Q:

1. That the second "Whereas" be changed to read: "WHEREAS, Efforts are being constantly exerted to indoctrinate our youth with the philosophy of socialism.

2. That the last paragraph be amended by changing the word "Ladies" to "Woman's."

On motion by Dr. Budd, seconded and carried, the recommendation of the committee, that Resolution Q, as amended, be adopted, was approved.

RESOLUTION R

Resolution R was submitted to the House of Delegates by The Council. It read as follows:

WHEREAS, A survey of the finances and activities of the Ohio State Medical Association by The Council has convinced The Council that an increase in the per capita annual dues of the Association will be necessary to insure the maintenance of the Association's present activities and services and to enable the Association to assume additional necessary services and programs, and

WHEREAS, The Council recommended a \$5.00 increase in the per capita annual dues in a statement adopted on December 10, 1955, which statement, setting forth detailed reasons for such increase, is appended to this resolution.

THEREFORE, BE IT RESOLVED, That the per capita annual dues of the Association shall be increased from \$20.00 to \$25.00, effective January 1, 1957.

The recommendation of the committee, that

this resolution be adopted, was approved on motion by Dr. Budd, seconded and carried.

RESOLUTION B

Resolution B was introduced by Henry C. Beekley, Cincinnati. It read as follows:

WHEREAS, The original objective of the Joint Commission on Accreditation of Hospitals was to improve the quality of medicine and surgical procedures in hospitals, the subsequent regulations enacted by the Commission now impose burdens on the physicians and hospitals that affect adversely the quality of medical and surgical care of patients, and

WHEREAS, There is reason to believe that many of the unnecessary and arbitrary directions are leading to an increase in hospital costs without a commensurate increase in the quality of hospital care or professional standards for the benefit of patients,

THEREFORE, BE IT RESOLVED, That the Ohio State Medical Association adopt the following recommendations:

(1) That the Joint Commission on Accreditation of Hospitals restrict accreditation to administrative operations and not attempt to appraise professional matters, which it is demonstrating more and more that it lacks the capacity to change. An unfortunate by-product of the Commission's activities has been that accreditation of hospitals has become a tacit and actually a de facto accreditation of residencies which is the proper function of the American Medical Association's Council on Medical Education and should not be within the province of the Joint Commission on Accreditation of Hospitals. Failure to accredit a hospital on the basis of legalistic administrative deficiencies should not be permitted to interfere with residency training or recruitment, nor should it imply that professional standards of that hospital are not adequate;

(2) That the Joint Commission on Accreditation of Hospitals revise its standards in order to provide more discretion for hospital authorities to make appropriate adjustment of their organizational activities to fit the hospital's particular needs and those of the community;

(3) That hospital staffs be permitted to determine for themselves how often they need to hold staff meetings and what kind of meeting is best suited to solve the problems of the individual hospital;

(4) That accreditation never be withheld from a hospital in which those questionable standards prevail until after a period of three to six months has expired and an opportunity has been given to the hospital to raise its standards within the period specified so that final action may never be taken on the report of just one investigator. When a hospital is taken off the accredited list, this fact should not be publicly advertised (as it usually is). The ill effect on the morale of the patients, employees, and house staff is inestimable. To correct this situation it is recommended that representatives of the Joint Commission on Accreditation of Hospitals meet with Council or the appropriate executive body of the county medical society or its designate within the city or town involved in order to give adequate explanation to the county medical society when the Joint Commission on Accreditation of Hospitals proposes to remove a hospital from the accredited list;

(5) That serious consideration be given to

the proposition by dissolving the Joint Commission on Accreditation of Hospitals;

(6) That the Ohio State Medical Association shall instruct its American Medical Association Delegates to implement the aforementioned resolution to the American Medical Association.

With respect to Resolution B, the Reference Committee on Resolutions reported as follows:

"Resolution B on problems involved in the accreditation of hospitals needs more study than time will permit at this meeting, in the opinion of your committee.

"Therefore, we recommend that the resolution be referred to the Committee on Hospital Relations of the Association; that the committee be directed to hold hearings on this question in the immediate future; that all County Medical Societies be invited to send representatives to such hearings; and that the committee prepare a report which can be considered by Ohio's AMA delegates as the basis for a resolution to be presented to the House of Delegates of the American Medical Association at the June, 1956, AMA meeting in Chicago."

On motion by Dr. Budd, seconded and carried, the recommendation of the committee, that this resolution be referred to The Council for hearings, was approved.

RESOLUTION P

Resolution P was introduced by Dr. B. C. Diefenbach, Martins Ferry. It read as follows:

WHEREAS, If organized medicine wishes to retain its rightful place in American medical practice and to continue a system which has given this country its pre-eminent position in the medical world it should take a firm stand early on matters which encroach upon the rights, abilities and ethical relations of its members.

THEREFORE, BE IT RESOLVED, That we go on record as opposing:

1. The gradual but increasing restriction on the acceptability of the general practitioner in Fund participation, the United Mine Workers Retirement and Welfare Fund or any similar group.

2. The issuance of over-all directives applicable to all physicians in an attempt to make any plan secure from the unethical practice of a few individuals or groups.

3. The payment of subsidies or retainers under any guise or label to any physician or group.

4. The qualification of any individual as a specialist except by a professional body such as the Specialty Boards, the professional colleges or the staff of an accredited hospital.

5. The coercion by local unions in attempting to secure hospital staff membership for physicians unacceptable to the hospital staff involved.

The committee reported that it had redrafted this resolution to clarify its meaning and to broaden its scope and that it recommended the adoption of the following Substitute Resolution P:

SUBSTITUTE RESOLUTION P

WHEREAS, Organized medicine wishes to retain its rightful place in American medical practice and to continue a system which has given this country its pre-eminent position in the medical world by taking a firm stand early on matters

which encroach upon the rights, privileges and obligations of its members.

THEREFORE, BE IT RESOLVED, That the House of Delegates of the Ohio State Medical Association go on record as opposing:

1. Gradually increasing restrictions on the acceptability of general practitioners for payment of fees from insurance or welfare funds.

2. The issuance of over-all directives that seemingly condemn and often handicap all physicians because of the alleged misdeeds of a few.

3. The use of economic or other types of pressure by any fund, insurance company or other agency to force patients to accept the services of any particular physician.

4. The qualification or disqualification of any individual as a specialist except on the basis of his hospital staff appointments.

5. The use of economic pressure or coercion by local unions or any other agencies in attempting to secure hospital staff membership for physicians unacceptable to the hospital staff involved.

Many discussed the motion. Numerous attempts to amend the substitute resolution were made and lost. A motion to refer the substitute resolution to The Council was defeated. A motion, which was seconded, to refer the committee's recommendation and the substitute resolution to the Committee on Public Relations and Economics was carried.

Later, Dr. Hopkins moved that the action referring the report and the substitute resolution to the Committee on Public Relations and Economics be reconsidered. The motion was seconded. A vote on this motion was taken and the motion was adopted.

The House of Delegates then reconsidered the recommendation of the Reference Committee on Resolution P. It was moved by Dr. Hopkins, seconded and carried that the recommendation of the committee that Substitute Resolution P be approved with the exception of paragraph 4 of the resolution and that paragraph 4 be referred to the Committee on Public Relations and Economics for further consideration.

RESOLUTION E

Resolution E was introduced by Dr. Sol Maggied, West Jefferson. It read as follows:

WHEREAS, Most practitioners of medicine are practicing a certain form of Socialized Medicine every time they fill out an Industrial Commission form, a Division of Aid for the Aged bill, a Veterans organization form or take part in any welfare program or immunization program sponsored and paid for by the State.

BE IT HEREBY RESOLVED, That the definition of "Socialized Medicine" be read as a preamble to each and every medical meeting.

A Substitute Resolution was drafted by the committee and presented to the House of Delegates with a recommendation that the substitute resolution be adopted. The substitute resolution read as follows:

SUBSTITUTE RESOLUTION E

WHEREAS, The medical profession must be constantly alert to the threats and dangers of socialized medicine, and

WHEREAS, All physicians should be made

aware of those programs and procedures which constitute socialized medicine,

THEREFORE, BE IT RESOLVED, That each County Medical Society devote more time at more meetings to discussions of the social, economic and legislative issues affecting the health of the public, the medical profession and the practice of medicine, as this, we believe, will tend to keep members properly informed and thus better prepared to act in unison as these vital issues arise.

On motion by Dr. Budd, seconded and carried, the recommendation of the committee, that the Substitute Resolution be adopted, was approved.

RESOLUTION C

Resolution C was introduced by Dr. Harry K. Hines, Cincinnati. It read as follows:

WHEREAS, The attainment and maintenance of highest caliber medical service is a primary concern of all dedicated physicians, and

WHEREAS, Such medical service is in a large measure dependent upon an intimate and personal doctor-patient relationship, and

WHEREAS, Such relationship cannot exist as a corporation-patient relationship, or more specifically, hospital-patient relationship, and

WHEREAS, Anesthesiology, radiology and pathology and all their aspects are defined as the practice of medicine, and

WHEREAS, Hospitals and other corporations charging patients for any of these services have been declared by court decision to be engaged in the practice of medicine,

THEREFORE, BE IT RESOLVED, That the Ohio State Medical Association reaffirm its policy of opposition to the practice of medicine by hospitals or other corporations, and

BE IT FURTHER RESOLVED, That the Ohio State Medical Association declare and emphasize its policy by supporting county medical societies in their opposition to any violation of this policy anywhere in the State of Ohio and that the Delegates to the American Medical Association be instructed to present a similar resolution to the American Medical Association for adoption and enforcement on a nationwide basis, and

BE IT FURTHER RESOLVED, That this action shall in no way be construed as contradictory to or at variance with the Principles of Medical Ethics of the American Medical Association concerning individual physicians engaged in contract medicine, or as salaried employees of insurance, business or industrial corporations.

The committee presented a substitute resolution C reading as follows:

SUBSTITUTE RESOLUTION C

WHEREAS, The attainment and maintenance of highest caliber medical service is a primary concern of all dedicated physicians, and

WHEREAS, Such medical service is in a large measure dependent upon an intimate and personal doctor-patient relationship, and

WHEREAS, Such relationship may be jeopardized through the intervention of a third party such as a hospital or other corporation,

THEREFORE, BE IT RESOLVED, That the Ohio State Medical Association reaffirm its policy of opposition to the corporate practice of medicine.

On motion by Dr. Budd, seconded and carried,

the recommendation of the committee, that the substitute resolution be adopted, was approved.

RESOLUTION G

Resolution G was introduced by Dr. C. P. Swett, Lancaster. It read as follows:

WHEREAS, The distribution of poliomyelitis vaccine has been unsatisfactory from the time of its original release, and

WHEREAS, The entrance of the Federal government into the market added disorder to the state of confusion which already existed and

WHEREAS, The socialistic planners greatly overestimated the desire of the American people to accept socialized medicine by the distribution of free vaccine and

WHEREAS, A distinct percentage of the vaccine in the possession of the Ohio Department of Health has become outdated without being administered and

WHEREAS, Practicing physicians are still unable to secure adequate supplies of the vaccine,

THEREFORE, BE IT RESOLVED, That the Ohio State Medical Association should endeavor to secure the release of more vaccine into commercial channels where Health Departments are oversupplied. It is further recommended that the distribution of the vaccine should be totally removed from Federal control.

An amended resolution, reading as follows, was presented by the committee and, on motion by Dr. Budd, seconded and carried, the recommendation of the committee, that the amended resolution be adopted, was approved.

AMENDED RESOLUTION G

WHEREAS, The distribution of poliomyelitis vaccine has been unsatisfactory from the time of its original release, and

WHEREAS, The entrance of the Federal government into the market added disorder to the state of confusion which already existed and

WHEREAS, The socialistic planners greatly overestimated the desire of the American people to accept socialized medicine by the distribution of free vaccine and

WHEREAS, A portion of the vaccine in the possession of certain health departments has become outdated without being administered and

WHEREAS, Practicing physicians are still unable to secure adequate supplies of the vaccine,

THEREFORE, BE IT RESOLVED, That the Ohio State Medical Association should endeavor to secure the release of more vaccine into commercial channels where Health Departments are oversupplied. It is further recommended that the distribution of the vaccine should be totally removed from Federal control.

RESOLUTION D

Resolution D was introduced by Dr. Sol Maggied, West Jefferson. It read as follows:

WHEREAS, The high standards of the health of this nation are well known and are the result of public education and enlightenment together with the system of private practice of medicine as practiced in this country, and the standards must be maintained, and

WHEREAS, Already established agencies exist for the care of the indigent in this country and have performed this service excellently in the past, and

WHEREAS, Established channels of drug distribution in this country are efficient and equitable

and should not be needlessly distorted or obstructed, and

WHEREAS, Federal intervention in private enterprise too frequently results in delay, waste, confusion, excessive cost and other inequities,

THEREFORE, BE IT RESOLVED, That the Congress of the United States should purchase no more Salk vaccine but should allow the matter to be resolved by the already existing organizations in whose province the matter properly lies.

The committee presented an amended Resolution D, reading as follows:

AMENDED RESOLUTION D

WHEREAS, The high standards of the health of this nation are well known, and are the result of public education and enlightenment together with the system of private practice of medicine as practiced in this country and the standards must be maintained, and

WHEREAS, Already established agencies exist for the care of the indigent in this country and have performed this service excellently in the past, and

WHEREAS, Established efficient channels of drug distribution in this country should not be needlessly handicapped, and

WHEREAS, Federal intervention in private enterprise too frequently results in delay, waste, confusion, excessive cost and other inequities,

THEREFORE, BE IT RESOLVED, That we urge the Congress of the United States to take steps to have the Federal Government discontinue as soon as possible the purchase of Salk vaccine and allow the matter to be resolved by the already existing organizations in whose province the matter properly lies.

On motion by Dr. Budd, seconded and carried, the committee's recommendation, that the amended resolution be approved, was adopted.

RESOLUTION A

Resolution A was introduced by Dr. Perry R. Ayres, Columbus. It read as follows:

(1) RESOLVED, that (a) we object to the Federal Poliomyelitis Distribution and Use Program established by Public Law 377, which stipulates that no means test or other financial discriminatory methods be used in dispensing the vaccine. Contrary to the intent and spirit of the program, this has resulted in many persons obtaining vaccine under the Federal Program who could and should have obtained it from their private physicians; that (b) because of the innate weakness in Public Law 377, the Federal Program represents an infringement upon the private practice of medicine, and does not protect, or insure the protection of, the individuals for whom it was intended.

(2) WHEREAS, statistics made available to our Committee by the Ohio Department of Health March 7, 1956, show that approximately 60 per cent of the total supply of poliomyelitis vaccine received in Ohio has been diverted to commercial channels and 40 per cent has been purchased by the State Health Department under the Federal Program, and that there is a great discrepancy between this ratio and that recommended by the Governor's Advisory Committee, which stipulated that 80 per cent of the vaccine would be made available to private physicians through commercial channels and 20 per cent distributed by the state for inoculation of those dependent on public resources for such services, therefore,

BE IT RESOLVED, that this Committee register strong objections to the departure from the recommendations of the Governor's Advisory Committee and suggests that the recommendations of the latter Committee, as noted above, be established as quickly as possible.

The committee presented a Substitute Resolution A, reading as follows:

SUBSTITUTE RESOLUTION A

WHEREAS, Statistics made available to the Polio Committee of the Columbus Academy of Medicine by the Ohio Department of Health on March 7, 1956, show that approximately 60 per cent of the total available supply of poliomyelitis vaccine received in Ohio has been diverted to the regular drug trade channels and 40 per cent has been purchased by the State Health Department under the Federal Program, and

WHEREAS, There is a great discrepancy between this ratio and that recommended by the Governor's Advisory Committee, which stipulated that 80 per cent of the vaccine should be made available to private physicians through the regular channels of the drug trade and 20 per cent distributed by the State for inoculation of those dependent on public resources for such service, and

WHEREAS, The Federal poliomyelitis distribution and use program established by Public Law 377 stipulates that no means test be used in dispensing the vaccine, and

WHEREAS, Under Public Law 377 the Federal program fails to protect the individuals for whom it was intended,

THEREFORE, BE IT RESOLVED, That the House of Delegates of the Ohio State Medical Association urge that the recommendations of the Governor's Advisory Committee be put into effect just as soon as possible and practical.

On motion by Dr. Budd, seconded and carried, the committee's recommendation, that the substitute resolution be approved, was adopted.

RESOLUTION H

Resolution H was introduced by Dr. Roger A. Peatee, Bowling Green. It read as follows:

WHEREAS, The Wood County Medical Society entertains a full appreciation of the benefits of The Blue Shield Plan to patients, and

WHEREAS, Payment thereunder have heretofore been made directly to the patient, and

WHEREAS, In many instances the proceeds thereof are used or expended by the patient for purposes other than payment to the doctor,

NOW, THEREFORE, BE IT RESOLVED, By the Wood County Medical Society that it recommend to the Ohio State Medical Association that The Blue Shield Plan be revised to place into effect a method whereby all remittances for medical payment under The Blue Shield Plan be made payable to both the patient (or the assured) (or the contractee) and the attending physician or surgeon to the end that the endorsement of the attending physician or surgeon be also required as necessary endorsements upon all such remittances.

The report of the Committee on Resolution H read as follows:

"After careful consideration of Resolution H and of the evidence and comments presented, it is the recommendation of the committee that this

resolution not be adopted for the following reasons:

"1. The only contractual legal obligation of Blue Shield is to pay the specified indemnity to the patient.

"2. Many physicians prefer that payments not be made to them by Blue Shield as it implies the bill is being paid in full, when in fact the amount involved is an indemnity and in some instances may not coincide with the amount of the doctor's bill.

"3. Routine direct payment by an insurance company to a doctor by-passes and eliminates the doctor-patient relationship which we are anxious to maintain.

"4. Finally, attention is called to the fact that any physician who may want his name included on a check issued to a subscriber may do so by having the subscriber sign an authorization to that effect, affixing such signed authorization to the claim form. This is now being done and complied with by Ohio Medical Indemnity. It is suggested that publicity be given to this fact through the publications of the Ohio State Medical Association."

On motion by Dr. Budd, seconded and carried, the recommendation of the committee, that Resolution H not be adopted, was approved.

RESOLUTION F

Resolution F was introduced by Dr. Edgar S. Lotspeich, Cincinnati. It read as follows:

WHEREAS, Whenever Blue Shield policy holders are so-called "No Pay" or "Part Pay," it is common practice for physicians to comply with requests by hospital administrators to endorse Blue Shield payment to the hospital, and

WHEREAS, Such payment by Blue Shield directly to hospitals constitutes the corporate practice of medicine,

THEREFORE BE IT RESOLVED, That the Ohio State Medical Association instruct the Ohio Medical Indemnity, Inc., not to make or direct payments to hospitals for medical service, and

BE IT FURTHER RESOLVED, That the Ohio State Medical Association instruct its members not to endorse Blue Shield payments to hospitals.

The report of the committee on Resolution F read as follows:

"Resolution F deals with endorsement by doctors to hospitals of payments made by Blue Shield. On analysis and consideration of the separate sections of the resolution, the following opinions are expressed by the committee:

"1. The decision as to what he shall do with a check received for professional services rests with the individual physician.

"2. The refusal of Ohio Medical Indemnity, Inc., to recognize any valid assignment submitted by a subscriber would be illegal.

"3. If physicians and hospitals are engaged in procedures which constitute the corporate practice of medicine or which are unethical, those matters should be considered by the local medical society involved.

"Your committee therefore recommends that Resolution F not be adopted."

On motion by Dr. Budd, seconded and carried, the recommendation of the committee, that resolution F not be adopted, was approved.

RESOLUTION N

Resolution N was introduced by Dr. J. B. Hazard, Cleveland. It read as follows:

WHEREAS, It is essential for the purpose of developing a more adequate representation and continuity of effort on behalf of the Ohio State Medical Association that not only the duly elected delegates attend and represent the Ohio State Medical Association at each meeting of the American Medical Association but that the alternate delegates also have the opportunity to participate in and learn from the deliberations of the reference committees, observe the procedures of the House of Delegates and assume active responsibility in the Ohio State Medical Association delegation causes,

THEREFORE, BE IT RESOLVED, That Ohio State Medical Association alternate delegates shall henceforth be sent to the American Medical Association House of Delegates sessions, and

BE IT FURTHER RESOLVED, That each alternate delegate shall receive the same travel and per diem reimbursement as the delegates shall receive.

The report of the Resolutions Committee on Resolution N read as follows:

"Resolution N advocates that alternate delegates to the American Medical Association be sent to each meeting of the A. M. A. House of Delegates and that their expenses be paid by the State Association.

"We recommend that this resolution not be adopted for the following reasons:

"Unlike our delegates whose expenses are paid, such alternates would not be permitted to take an official part in the A. M. A. House of Delegates activities. Of course, alternates who may be in attendance at A. M. A. meetings are privileged to sit in at all House of Delegates sessions as observers, to attend all reference committee hearings, and be present at caucuses of the Ohio delegates.

"Actually, your committee believes that alternate delegates would better prepare themselves to assume official responsibilities in the A. M. A. House of Delegates, should they be called upon to do so, if they would attend meetings of The Council and the various committees of the State Association, meetings of the House of Delegates of the State Association, and meetings of the Reference Committee on Resolutions. At these meetings important issues are considered and policies of the Ohio State Medical Association are formulated. Knowledge of these matters would enhance the value of those representing us in the A. M. A. House of Delegates. Our delegates attend many of these meetings. We suggest that alternate delegates be notified of all such meetings and urged to attend them.

On motion by Dr. Budd, seconded and carried,

the recommendation of the committee, that Resolution N not be adopted, was approved.

RESOLUTION J

Resolution J was presented by Dr. Charles W. Hoyt, Cincinnati. It read as follows:

WHEREAS, Articles published in Ohio newspapers in recent months state that Blue Cross is operating at a loss and it was necessary to increase the fee to all subscribers, in which statements the medical profession as a whole was severely criticized for contributing to the difficulties of the hospitals and Blue Cross by unnecessary hospitalization, excessive ordering of diagnostic and therapeutic measures, and keeping patients in the hospitals longer than necessary, and

WHEREAS, Hospitals were advised to be wary of increasing the number of hospital beds because of possible financial loss due to empty beds, and

WHEREAS, The medical profession has co-operated wholeheartedly with Blue Cross and its member hospitals, it deplors these statements which are detrimental to the good relationship that exists between physicians, hospitals and Blue Cross, and

WHEREAS, Proposals are under discussion to extend outpatient care by including x-ray, laboratory facilities, etc., to outpatients under Blue Cross and/or Blue Shield, therefore it is recommended that the Ohio State Medical Association adopt the following resolution:

RESOLVED, That the Ohio State Medical Association regrets whatever financial trouble the hospitals and Blue Cross may be having but it is not just or proper to indict the medical profession for these difficulties based on the following reasons:

(a) Physicians do not control the general administration of hospitals, do not set the hospital fees and have little or nothing to do with administrative costs;

(b) Physicians do not own, operate or set the policies of Blue Cross, these being functions of the member hospitals;

(c) In this day of acute bed shortages with practically only emergency and urgent cases being accepted and these admissions are being policed by nurses, the administrator and various committees of the staff, it is difficult to understand that much unnecessary hospitalization could occur. The hospitals have adequate methods for the control of the professional activities of their own staff members in these matters;

(d) Restrictive provisions are not adequately stated in Blue Cross policies nor are they fully advertised, and this throws an embarrassing burden on the attending physician;

BE IT FURTHER RESOLVED, That the Ohio State Medical Association cannot approve the limiting of hospital beds as a means of reducing the possibility of financial loss to the hospital. It cannot accept a philosophy of a planned economy based on shortages of doctors, nurses, or hospital beds. While limiting beds may be beneficial for financial purposes, it is detrimental to the health of the individual and the community, the medical profession's primary concern.

The committee presented a Substitute Resolution J reading as follows:

SUBSTITUTE RESOLUTION J

WHEREAS, Certain articles recently published in newspapers have stated that patients are sometimes permitted to stay in the hospital for periods longer than necessary and have stated

that on occasions there is an excessive usage of certain diagnostic procedures and of certain costly drugs and medication and these articles have charged that these alleged practices have contributed to the ever-spiraling costs of hospitals and the resulting increases in the fees charged by Blue Cross and some other hospitalization insurance companies to its subscribers, and

WHEREAS, The major factor in the rising cost of hospital administration is the high and ever-increasing cost of hospital personnel, and

WHEREAS, Physicians do not control the general administration and operation of hospitals and do not set the fees charged for hospital care, and

WHEREAS, The medical profession is vitally interested in seeing that the furnishing of hospital care to members of the public is conducted on an efficient and economically sound basis,

NOW, THEREFORE, BE IT RESOLVED, That the Ohio State Medical Association declare the willingness and desire of the medical profession of Ohio to cooperate wholeheartedly with the Boards of Trustees of all hospitals and with the various Blue Cross organizations in promoting the efficiency of hospital administration and operation and in the effecting of such economies therein as can be accomplished without lowering or impairing the high standard of medical care and treatment.

BE IT FURTHER RESOLVED, That this Association transmit to the Ohio Hospital Association and to the directors of the various Blue Cross organizations copies of this resolution and suggest to them that they make use of the joint conference plan advocated in the 'Joint Statement of Basic Principles,' recently adopted by the Ohio State Medical Association and the Ohio Hospital Association, as a means of promoting closer cooperation between the medical profession and hospital administration boards in the solving of the problems of their mutual interest and concern.

On motion by Dr. Budd, seconded and carried, the recommendation of the committee, that Substitute Resolution J be adopted, was approved.

On motion by Dr. Budd, seconded and carried, the report of the Committee on Resolutions, as amended, was approved.

Dr. Budd then thanked members of his committee for having devoted Tuesday night and all day Wednesday to consideration of the resolutions and for the efficient manner by which they had handled the complex proposals.

Dr. Orr then moved that the committee be commended for its efficiency and devotion. The motion was seconded and carried.

ELECTION OF OFFICERS

The next order of business was the election of officers.

Dr. Hudson pointed out that due to the fact that he had succeeded Dr. Heusinkveld as president, leaving a vacancy in the office of president-elect, and that The Council had taken no action to fill such vacancy, the House of Delegates would be required to elect a president as well as a president-elect.

ELECTION OF PRESIDENT

Dr. Hudson then called for nominations for the office of president. Dr. Geo. J. Hamwi, Columbus, placed in nomination the name of Dr. Richard L.

Meiling, Columbus, who has been serving as treasurer of the State Association. The nomination was seconded by Dr. Ralph W. Holmes of Chillicothe. There being no further nominations, on **motion** duly made, seconded and **carried**, the nominations were closed and Dr. Meiling was elected president by acclamation.

Dr. Hamwi and Dr. Holmes were asked to escort Dr. Meiling to the platform. This was done and Dr. Meiling made a brief talk accepting the honor and responsibilities of the office and assuring the membership of the House of Delegates that he would do everything possible to see that the work of the Association is carried on effectively and efficiently. He emphasized particularly the necessity for, and value of, strong County Medical Societies.

ELECTION OF PRESIDENT-ELECT

Dr. Hudson then called for nominations for the office of president-elect. Dr. A. C. Ormond, Zanesville, placed in nomination the name of Dr. Robert S. Martin, Zanesville, who has been serving as Councilor of the Eighth District. The nomination was seconded by Dr. R. Dean Dooley, Dayton. There being no further nominations, on **motion** duly made, seconded and **carried**, the nominations were closed and Dr. Martin was elected president-elect by acclamation. Dr. Martin was escorted to the platform by Dr. Ormond and Dr. Dooley. In a brief talk he thanked the House of Delegates for having bestowed this high honor on him and promised that he would do everything possible to see that the services and programs of the Association are continued on a high level.

ELECTION OF COUNCILORS

The report of the Nominating Committee was then presented by Dr. Harry K. Hines, Cincinnati, chairman. Action taken by the House of Delegates follows:

FIRST DISTRICT

For the office of Councilor for the First District the committee placed in nomination the name of Dr. Charles T. Atkinson, Middletown, to succeed himself for a term of two years. There being no further nominations, on **motion** duly made, seconded and **carried**, Dr. Atkinson was elected Councilor of the First District, by acclamation, for the years 1956 and 1957.

THIRD DISTRICT

For the office of Councilor of the Third District the committee placed in nomination the name of Dr. James R. Jarvis, Van Wert, to succeed himself for a term of two years. There being no further nominations, on **motion** duly made, seconded and **carried**, Dr. Jarvis was elected Councilor of the Third District, by acclamation, for the years 1956 and 1957.

FIFTH DISTRICT

For the office of Councilor of the Fifth District the committee placed in nomination the name of

Dr. George W. Petznick, Cleveland, to succeed himself for a term of two years. There being no further nominations, on **motion** duly made, seconded and **carried**, Dr. Petznick was elected Councilor of the Fifth District, by acclamation, for the years 1956 and 1957.

SEVENTH DISTRICT

For the office of Councilor of the Seventh District the committee placed in nomination the name of Dr. Robert E. Hopkins, Coshocton, to succeed himself for a term of two years. There being no further nominations, on **motion** duly made, seconded and **carried**, Dr. Hopkins was elected Councilor of the Seventh District, by acclamation, for the years 1956 and 1957.

NINTH DISTRICT

For the office of Councilor of the Ninth District the committee placed in nomination the name of Dr. C. L. Pitcher, Portsmouth, to succeed himself for a term of two years. There being no further nominations, on **motion** duly made, seconded and **carried**, Dr. Pitcher was elected Councilor of the Ninth District, by acclamation, for the years 1956 and 1957.

ELEVENTH DISTRICT

For the office of Councilor of the Eleventh District the committee placed in nomination the name of Dr. H. T. Pease, Wadsworth, to succeed himself for a term of two years. There being no further nominations, on **motion** duly made, seconded and **carried**, Dr. Pease was elected Councilor of the Eleventh District, by acclamation, for the years 1956 and 1957.

A. M. A. DELEGATES ELECTED

The committee presented the following nominations for the offices of delegate and alternate to the American Medical Association to be filled at this year's meeting, such delegates and alternates to start their terms January 1, 1957, and to serve for two years, namely the calendar years of 1957 and 1958:

Dr. Carl A. Lincke, Carrollton, delegate, and Dr. H. M. Platter, Columbus, alternate.

Dr. George A. Woodhouse, Pleasant Hill, delegate, and Dr. R. Dean Dooley, Dayton, alternate.

Dr. Herbert B. Wright, Cleveland, delegate, and Dr. Fred W. Dixon, Cleveland, alternate.

Dr. Charles L. Hudson, Cleveland, delegate, to succeed the late Dr. Wm. M. Skipp, Youngstown, and Dr. C. E. Hufford, Toledo, alternate.

There being no nominations from the floor for these positions, the nominations were closed and the foregoing nominees were elected, by acclamation, for two-year terms starting January 1, 1957.

NEW TREASURER ELECTED

Dr. Hudson then called to the attention of the House of Delegates the fact that it would be necessary for the House of Delegates to nominate and elect someone to serve the unexpired term of

Dr. Meiling as treasurer. Dr. Charles W. Pavey, Columbus, placed in nomination the name of Dr. Geo. W. Hamwi, Columbus. There being no further nominations, on **motion** duly made, seconded and **carried**, the nominations were closed and Dr. Hamwi was elected by acclamation to the office of treasurer for the unexpired term, namely, to serve during the years 1956 and 1957.

NEW EIGHTH DISTRICT COUNCILOR ELECTED

The House of Delegates was advised that it would be necessary to nominate and elect a successor to Dr. Robert S. Martin, Zanesville, as Councilor of the Eighth District. Dr. Swett placed in nomination the name of Dr. Wm. D. Monger, Lancaster. There being no further nominations, on **motion** duly made, seconded and **carried**, the nominations were closed and Dr. Monger was elected by acclamation to serve the unexpired term as Councilor of the Eighth District, namely, for one year.

The President announced that there had been an all-time record registration at this meeting, namely, a total registration of 3,577.

DR. SKIPP MEMORIALIZED

Dr. C. A. Gustafson, Youngstown, moved that a special committee be appointed to draft a suitable resolution with regard to the untimely death of the late Dr. Wm. M. Skipp, Youngstown, former president of the Association and long time member of the House of Delegates of the State Association and of the House of Delegates of the American Medical Association, and that the resolution be published in *The Journal* and a copy be sent to members of his family. The motion was seconded and adopted by a unanimous vote.

OFFICERS INSTALLED

Dr. Hudson then turned over the office of President to Dr. Meiling, presenting him with the official gavel of the Association.

President Meiling then installed into office the new officers, Councilors and A. M. A. delegates, asking all of them to rise so they could be properly recognized with applause by the House of Delegates.

Dr. Meiling advised the House of Delegates that he was not prepared at this time to present committee appointments for confirmation by the House. On **motion** duly made, seconded and **carried**, the House of Delegates directed President Meiling to confer with The Council, if necessary, on committee appointments.

Dr. Orr presented a motion extending appreciation and thanks to all who had any part in the arrangements and program for the 1956 Annual Meeting. The motion was seconded and unanimously adopted.

There being no further business, the House of Delegates adjourned sine die.

Attest: CHARLES S. NELSON,
Executive Secretary.

Narcotic Licenses Must Be Renewed by July 1

On or before July 1, every physician registered under the Harrison Narcotic Act, must (unless he is in military service) re-register with the Director of Internal Revenue of the district in which he maintains an office and pay the Federal Narcotic Tax of \$1. Initial application may be made at any time, but existing permits must be renewed on or before July 1, annually.

Revised Form 678, which is smaller than the previous form, will be mailed by the Narcotics Division early in June to physicians on record. But the physician is responsible for re-registering whether or not he receives a form. A penalty is incurred by those who fail to re-register before deadline. Gross violations of the Narcotic Act are punishable by heavy fines and imprisonment.

Physicians who administer, dispense or prescribe cannabis must obtain a special permit under the Marihuana Tax Act and pay an additional tax of \$1.

Ford Foundation Announces Matching Funds for Medical Education

The Ford Foundation has announced a \$10,000,000 program of matching grants to the National Fund for Medical Education, over a five-ten year period with a maximum limit in any one year of \$2,000,000.

These grants will be paid to the National Fund on a sliding scale in a program that could last up to ten years but might be accelerated to completion in five years, depending upon the rate at which additional contributions are developed.

In 1955 the National Fund received \$2,147,000 in un earmarked funds for distribution to the nation's medical schools. Of this amount, \$422,812 came from the medical profession through the American Medical Education Foundation, the balance from industry and the general public. Under the Ford Foundation formula, if these receipts are of equal magnitude in 1956, there would be a Ford grant totaling 70 per cent of this amount or \$1,503,486. All contributions in excess of the 1955 total would be matched dollar for dollar, subject to the annual maximum of \$2,000,000.

This new donation of the Foundation is distinct from its \$90,000,000 appropriation for endowment to be distributed direct to the nation's 42 privately supported medical schools.

In announcing the grant to the National Fund for Medical Education, H. Rowan Gaither, Jr., the Foundation President said: "The Ford Foundation is aware of the critical needs of the nation's medical schools and of the threat to the national welfare posed by their current plight."

HOUSE OF DELEGATES ROLL CALL—1956 MEETING

County	Delegate	First Session	Second Session
FIRST DISTRICT			
ADAMS	R. L. Woodyard	Present	Present
BROWN			
BUTLER	W. A. Reese	Present	
CLERMONT	Carl A. Minning		Present
CLINTON			
HAMILTON	Henry C. Beekley	Present	
	Harry K. Hines	Present	Present
	Charles W. Hoyt	Present	Present
	J. Robert Hudson	Present	Present
	Daniel V. Jones	Present	Present
	E. S. Lotspeich, Jr.	Present	Present
	William A. Moore		Present
HIGHLAND	J. Martin Byers	Present	Present
WARREN			
SECOND DISTRICT			
CHAMPAIGN	I. Miller	Present	Present
CLARK	J. H. Shanklin	Present	
	Ray M. Turner	Present	Present
DARKE	Maurice M. Kane	Present	Present
GREENE	Paul D. Espey	Present	Present
MIAMI	Dale A. Hudson	Present	Present
MONTGOMERY	R. Dean Dooley	Present	Present
	Richard S. Graves		Present
	T. L. Light	Present	Present
	William R. Love		Present
	Robert E. Pumphrey	Present	Present
PREBLE	C. J. Brian	Present	Present
SHELBY			
THIRD DISTRICT			
ALLEN	Fred P. Berlin		Present
AUGLAIZE	Clyde W. Perry		Present
CRAWFORD	James E. Loggins	Present	
HANCOCK	Harold K. Treece	Present	Present
HARDIN	Floyd M. Elliott	Present	Present
LOGAN	H. L. Mikesell	Present	Present
MARION	M. S. Olson	Present	
MERCER	Julius Schwieger	Present	
SENECA	Walter A. Daniel	Present	
VAN WERT	E. W. Burnes		Present
WYANDOT	Allen F. Murphy	Present	Present
FOURTH DISTRICT			
DEFIANCE	James E. Cameron	Present	
FULTON	C. S. Kellogg	Present	Present
HENRY	Thomas F. Tabler	Present	Present
LUCAS	Warren Baird	Present	Present
	C. L. Felker	Present	Present
	J. L. Kobacher	Present	Present
	Frank F. A. Rawling	Present	Present
	Howard E. Smith	Present	Present
	G. H. Start	Present	Present
	Geo. A. Boon	Present	Present
OTTAWA			
PAULDING			
PUTNAM			
SANDUSKY			
WILLIAMS	J. M. Riesen	Present	Present
WOOD	Roger A. Peatee	Present	Present
FIFTH DISTRICT			
ASHTABULA	S. A. Burroughs	Present	Present
CUYAHOGA	James O. Barr	Present	Present
	J. L. Bilton	Present	Present
	F. L. Browning	Present	Present
	John H. Budd	Present	Present
	A. C. Corcoran	Present	Present
	E. A. Ferreri		Present
	H. A. Haller	Present	Present
	John B. Hazard	Present	Present
	H. D. Iler	Present	Present
	C. R. Jablonski	Present	Present
	F. R. Kelly	Present	Present
	Thomas D. Kinney	Present	Present
	T. W. Knickerbocker	Present	
	Geo. R. Krause		Present
	M. H. Lambright	Present	Present
	A. Macon Leigh		Present
	Paul A. Mielcarek	Present	Present
	Frank Rack	Present	
	J. M. Rossen	Present	Present
	Paul J. Schildt	Present	
	K. W. Sheldon	Present	Present
	Edwin L. Smith	Present	Present
	Dale J. Hawk	Present	Present
GEAUGA			
LAKE	B. S. Park		Present

County	Delegate	First Session	Second Session
SIXTH DISTRICT			
COLUMBIANA	John A. Fraser	Present	Present
MAHONING	Paul J. Mahar	Present	Present
	M. W. Neidus	Present	Present
	Asher Randell		Present
PORTAGE	Arthur Knight	Present	
STARK	John R. Seesholtz	Present	Present
	R. E. Tschantz		Present
	J. L. Yahraus	Present	Present
SUMMIT	Arthur Dobkin	Present	Present
	A. F. Dörner	Present	Present
	Donald I. Minnig	Present	Present
	H. O. Musser	Present	Present
	Carl C. Nohe	Present	Present
TRUMBULL	E. G. Caskey	Present	Present
	E. R. Westbrook	Present	Present
SEVENTH DISTRICT			
BELMONT	B. C. Diefenbach	Present	Present
CARROLL	Joseph D. Stires	Present	Present
COSHOCTON	G. A. Foster		Present
HARRISON			
JEFFERSON	C. F. Goll	Present	Present
MONROE			
TUSCARAWAS	J. W. Hamilton	Present	Present
EIGHTH DISTRICT			
ATHENS	Chester P. Swett	Present	Present
FAIRFIELD	James A. L. Toland	Present	Present
GUERNSEY	John Fleek Miller	Present	Present
LUCKING	Henry Bachman	Present	
MORGAN	A. A. Coulson		Present
	A. C. Ormond	Present	Present
MUSKINGUM			
NOBLE			
PERRY	C. B. McDougal		Present
WASHINGTON	K. E. Bennett		Present
NINTH DISTRICT			
GALLIA	N. W. Pinschmidt	Present	Present
HOCKING	C. T. Grattidge	Present	Present
JACKSON	A. R. Hambrick	Present	Present
LAWRENCE	George N. Spears	Present	Present
MEIGS	Roger P. Daniels	Present	Present
PIKE			
SCIOTO	Oral D. Tatje	Present	Present
VINTON			
TENTH DISTRICT			
DELAWARE	Robert S. Caulkins	Present	Present
FAYETTE			
FRANKLIN	Perry R. Ayres	Present	Present
	Geo. J. Hamwi	Present	Present
	Warren G. Harding	Present	Present
	R. M. Inglis	Present	Present
	Charles W. Matthews	Present	Present
	Charles W. Pavey	Present	Present
	M. P. Sayers	Present	Present
KNOX	Henry T. Lapp	Present	Present
MADISON	Sol Maggied	Present	Present
MORROW	Joseph P. Ingmire	Present	Present
PICKAWAY	Robert G. Smith	Present	Present
ROSS	Ralph W. Holmes	Present	Present
UNION	E. J. Marsh	Present	Present
ELEVENTH DISTRICT			
ASHLAND	M. D. Shilling	Present	
ERIE	E. J. Meckstroth	Present	Present
HOLMES	N. P. Stauffer	Present	Present
HURON	O. J. Nicholson	Present	Present
LORAIN	Ben V. Myers	Present	Present
	G. R. Wiseman		Present
	R. F. Fasoli	Present	Present
MEDINA	R. H. Barnes	Present	Present
RICHLAND	H. G. Knierim	Present	Present
WAYNE	A. B. Huff		Present
OFFICERS			
President	Charles L. Hudson	Present	Present
Past-President	M. D. Prugh	Present	Present
Treasurer	R. L. Meiling	Present	Present
COUNCILORS			
District	Charles T. Atkinson		
First	G. A. Woodhouse	Present	Present
Second	J. R. Jarvis	Present	Present
Third	Paul F. Orr	Present	Present
Fourth	George W. Petznick	Present	Present
Fifth	C. A. Gustafson	Present	Present
Sixth	R. E. Hopkins	Present	Present
Seventh	Robert S. Martin	Present	Present
Eighth	C. L. Pitcher	Present	Present
Ninth	E. H. Artman	Present	Present
Tenth	H. T. Pease	Present	Present
Eleventh			
Totals		123	128

Annual Meeting Attendance . . .

Record Attendance Is Registered at Cleveland Session, April 10-12
With Total of 3,577; List of Members Present and Other Data Given

AN ALL-TIME record attendance for an Annual Meeting, both in number of Association members and others present, was registered at the Cleveland meeting, April 10-12. The total attendance was 3,577, which was subdivided as follows: Members of the Association, 1,601; Interns, residents and guest physicians, 324; out-of-state guest physicians, 14; medical students, 120; exhibitors, scientific, excluding members, 57; technical exhibitors, 432; Woman's Auxiliary members, 423; miscellaneous guests, including nurses, technicians, dentists, etc., 606.

Following are registration figures by counties, a comparison of attendance at Annual Meetings from 1919 through 1956, followed by the roster of members who registered:

REGISTRATION, 1956 ANNUAL MEETING BY
COUNTIES, AND MEMBERSHIP DATA

County	Total Membership		Annual Meeting Registration
	Dec. 31, '55	Apr. 6, '56	
Adams	10	10	1
Allen	103	104	19
Ashland	26	25	7
Ashtabula	59	59	6
Athens	33	32	4
Auglaize	19	20	3
Belmont	54	50	4
Brown	13	12	0
Butler	146	138	9
Carroll	8	8	3
Champaign	21	17	4
Clark	120	107	14
Clermont	26	26	1
Clinton	23	18	3
Columbiana	76	55	11
Coshocton	21	20	5
Crawford	32	33	12
Cuyahoga	1,959	1,869	646
Darke	25	24	4
Defiance	17	13	3
Delaware	21	23	4
Erie	58	54	14
Fairfield	47	45	2
Fayette	14	16	2
Franklin	786	709	105
Fulton	25	23	2
Gallia	31	33	4
Geauga	10	10	5
Greene	43	39	6
Guernsey	37	35	8
Hamilton	1,139	1,082	48
Hancock	42	41	7
Hardin	29	22	2
Harrison	10	11	3
Henry	12	13	2
Highland	23	23	3
Hocking	8	11	2
Holmes	9	8	4
Huron	24	23	7
Jackson	17	16	2
Jefferson	54	43	5
Knox	33	34	5
Lake	53	56	18
Lawrence	25	22	5
Licking	64	59	9
Logan	27	26	7
Lorain	151	142	51
Lucas	525	505	60
Madison	12	7	2
Mahoning	263	252	51
Marion	54	54	9
Medina	34	35	14
Meigs	11	9	1
Mercer	19	19	4
Miami	49	55	13
Monroe	4	4	-
Montgomery	455	418	28
Morgan	6	5	2

REGISTRATION, 1956 ANNUAL MEETING BY
COUNTIES, AND MEMBERSHIP DATA

County	Total Membership		Annual Meeting Registration
	Dec. 31, '55	Apr. 6, '56	
Morrow	8	9	7
Muskingum	58	61	8
Noble	3	3	-
Ottawa	16	17	4
Paulding	12	9	1
Perry	11	12	2
Pickaway	15	15	1
Pike	13	10	-
Portage	37	38	11
Preble	12	11	1
Putnam	14	13	3
Richland	106	105	24
Ross	49	49	14
Sandusky	43	40	5
Scioto	74	73	9
Seneca	40	39	10
Shelby	18	19	1
Stark	299	296	54
Summit	417	415	89
Trumbull	114	116	24
Tuscarawas	49	54	20
Union	21	20	7
Van Wert	16	16	3
Vinton	4	3	-
Warren	14	5	-
Washington	26	26	3
Wayne	59	53	13
Williams	17	15	2
Wood	38	36	5
Wyandot	15	14	4
Totals	8,633	8,214	1,601

ANNUAL MEETING REGISTRATION FOR
1919-1956 INCLUSIVE

Year	Place	Members	Guest Physicians	Medical Students	Woman's Aux. ;		Sc. and Tech. Exhibitors	Total
					Misc. Guests			
1919	Columbus	1173			264		92	1539
1920	Toledo	860			105		80	1062
1921	Columbus	1275			104		96	1503
1922	Cincinnati	1066			184		70	1341
1923	Dayton	1117			202		76	1414
1924	Cleveland	1301			180		109	1603
1925	Columbus	1204			361		107	1689
1926	Toledo	903			120		83	1125
1927	Columbus	1320			286		82	1705
1928	Cincinnati	916			92		80	1115
1929	Cleveland	1231			249		124	1619
1930	Columbus	1241			435		86	1775
1931	Toledo	826			198		50	1087
1932	Dayton	978			201		45	1226
1933	Akron	858			160		25	1049
1934	Columbus	1069			410		51	1539
1935	Cincinnati	973			197		84	1271
1936	Cleveland	1099			563		137	1813
1937	Dayton	1103			366		64	1551
1938	Columbus	1330			619		104	2068
1939	Toledo	1056			271		84	1426
1940	Cincinnati	1126			323		114	1589
1941	Cleveland—Joint Meeting with A. M. A.							
1942	Columbus	1221			527		119	1880
1943	Columbus	544			160			717
1944	Columbus	830			441		130	1421
1945	No Meeting							
1946	Columbus	1262	130	65	507		157	2121
1947	Cleveland	1502	158	15	411		328	2414
1948	Cincinnati	1362	293	27	491		214	2387
1949	Columbus	1533	162	221	462		230	2608
1950	Cleveland	1587	260	102	707		376	3032
1951	Cincinnati	1208	162	185	647		352	2554
1952	Cleveland	1366	204	49	687		395	2701
1953	Cincinnati	1155	180	224	578		298	2435
1954	Columbus	1222	197	173	701		252	2545
1955	Cincinnati	1360	211	184	738		317	2810
1956	Cleveland	1601	338	120	1029		489	3577

MEMBERS OF STATE ASSOCIATION REGISTERED AT 1956 MEETING

Adams County—Richard L. Woodyard.

Allen County—John D. Albertson, Andrew M. Barone, Margaret E. Belt, Fred P. Berlin, Raymond B. Croissant, Thomas L. Edwards, Raymond P. Epstein, Bernard Glass, John A. Glorioso, Frederick A. Hemsath, John D. Hubbell, Charles H. Leech, Walter Armstrong Noble, Alfred W. Pinkerton, Franklin D. Rodabaugh, Hugh J. Savage, David L. Steiner, Herbert A. Thomas, Harold C. Weisenbarger.

Ashland County—Paul Kellogg, Harold V. Marley, R. Lee Schafer, Myrle D. Shilling, Myron A. Shilling, Carl Stein, Howard R. Wetzel.

Ashtabula County—Shepard A. Burroughs, J. Jason Dixon, Stephen E. Gates, Richard C. Irving, Harry K. Lynne, R. E. Stoops.

Athens County—Arthur L. Dobosiewicz, Hubert H. Fockler, Charles F. Jividen, Beatrice Postle.

Auglaize County—Clyde W. Berry, Michael Rabe, James R. Romaker.

Belmont County—B. C. Diefenbach, Murray B. Hunter, Charlotte C. Levine, Frederick P. Sutherland.

Butler County—Donald M. Blizzard, Walter E. Fening, Jack L. Harris, William H. Henry, Anthony G. Kokinakis, Walter A. Reese, Bernard H. Roberts, Martin A. Rush, Jr., Gene M. Thompson.

Carroll County—Carl A. Lincke, Joseph D. Stires, P. S. Whiteleather.

Champaign County—Isadore Miller, John K. Pond, Arthur B. Ream, Myron J. Towle.

Clark County—Frank W. Anzinger, Jr., Martin J. Cook, William J. Habeeb, John F. Harley, Dorothy C. Heinz, Clarence W. Hullinger, Wesley E. Knaup, John D. LeFevre, Morris B. Martin, William H. Miller, D. Joseph Parsons, J. Harold Shanklin, Ray M. Turner, Starling C. Yinger.

Clermont County—Carl A. Minning.

Clinton County—Foster J. Boyd, Jr., William L. Wead, John K. Williams.

Columbiana County—Guy E. Byers, Roy C. Costello, John A. Fraser, R. T. Holzbach, George O. Kemeny, A. J. Knapp, William A. Kolozsi, Carl J. Lehwald, E. C. Louthan, Ernest P. Schaefer, William F. Stevenson.

Coshocton County—W. R. Agricola, G. A. Foster, Robert E. Hopkins, Robert R. Johnson, Howard H. Schwindt.

Crawford County—Jack W. Arnold, Karl H. Barth, Darrel D. Bibler, H. M. Brooks, Arnold Eicens, Charles J. Griebeling, Carl J. Ide, Gotholds Kalnins, James E. Loggins, Robert L. Solt, Malcolm E. Switzer, Donald R. Wenner.

Cuyahoga County—Harold J. Abrams, Sol B. Abrams, Angela B. Adams, Wendall W. Adams, Fred Adelstein, Nelson J. Adelstein, Donald G. Allen, Hugh Amos, John B. Anderson, John P. Anderson, F. W. Andreas, Joseph G. Arday, Abraham Arons, Ward M. Athey, Anatans Azelis, Elmer J. Ballintine, Alfred K. Bard, Harold J. Barker, Allan C. Barnes, Charles A. Barnes, James O. Barr, Thomas J. Barrett, Walter M. Barth, Robert R. Bartunek, Norman Bash, Garry G. Bassett, John Battle, Jr., Luther O. Baumgardner, Richard P. Bell, Stephen R. Beluk, Albert R. Bennett, Alwyn E. Bennett, James E. Bennett, Benjamin Berger, Irving L. Berger, Leopold Bergmann, David H. Berman, Francis F. Berthold, Irving W. Besserglick, Stacey A. Besst, Harold

B. Bilsky, Joseph L. Bilton, Brian Bird, Edward J. Bishop, Joseph L. Bitzan, Joseph M. Black, Richard A. Bloomfield, Otto W. Blum, J. W. Blunt, Willard D. Boaz, Julius J. Boldizar, William H. Bond, Thomas H. Borland, Robert E. Bowman, Alfred V. Boysen, Malcolm A. Brahms, Samuel R. Brandwan, Don D. Brannan, Samuel Braun, Elizabeth A. Bremner, John D. Brett, Ernest F. Bright, Melvin Brody, A. S. Broglio, Louis H. Brooks, George H. Brown, Henry W. Brown, Joseph E. Brown, Francis L. Browning, John H. Budd, Simon Bunin, Alexander T. Bunts, Harold F. Burkons, Andre Callot, Frank J. Calo, R. L. Cameron, A. Elizabeth Cannon, Chalmers J. Carothers, Hilda B. Case.

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(Continued on page 640)

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(Continued on page 642)

Scioto County—Donald M. Appleton, Clyde W. Everett, Ralph W. Lewis, Thomas A. McMahon, Alden B. Oakes, Carter L. Pitcher, Henry F. Rogowski, Marie B. Rogowski, Oral D. Tatje.

Seneca County—Henry L. Abbott, Walter A. Daniel, William R. Funderburg, Lawton C. Gerlinger, Richard A. Leahy, E. F. Ley, Frank H. Pennell, Robert E. Schriener, H. P. Ulicny, Richard R. Waite.

Shelby County—H. Eugene Crimm.

Stark County—Laurence E. Anderson, Robert H. Angerman, A. R. Basinger, Hiram J. Bazzoli, Edmund Beshara, A. E. Boyles, Harold H. Brueckner, John R. Caldwell, Alfons Cecys, Stoyan P. Daskalov, Samuel J. Feingold, George S. Hackett, Ian B. Hamilton.

W. P. Hanna, Melvin W. Harris, Jack G. G. Hendershot, Robert R. Hirst, A. H. Karam, K. Wm. Kennedy, Douglass S. King, Joseph B. Klein, David E. Leavenworth, Karl L. Lehmler, Joseph J. Leven, William A. McCrea, John W. McFadden, David O. McKee, James A. McNalley, Louis E. Mueller, Howard S. Myers, Keith C. Noble, A. R. Olmstead, John R. Peffer, Otto L. Plaut, Wade R. Portz, Ralph K. Ramsayer, Donald L. Ream, Edward C. Reno, William E. Sag, W. H. Schumaker, Paul C. Schwallie, John R. Seesholtz, Maurice E. Stilwill, Franklin D. Swan, John M. Thomas, John F. Thompson, Elijah White Titus, Jr., Robert E. Tschantz, Graydon D. Underwood, Ernest R. Valentine, John M. Van Dyke, Constantine C. Vishnevsky, Homer V. Weaver, George M. Wilcoxon, Jack L. Yahraus.

Summit County—Harry Anker, Peter Z. Arapakis, John Bakos, Jr., Jess H. Bond, Merle F. Bossart, Charles V. Bowen, Jr., John L. Brickwede, Earl W. Burgner, Edwin W. Cauffield, Richard H. Champion, F. A. Cleary, Paul A. Davis, Roger Q. Davis, Philip B. DeMaine, Arthur Dobkin, Arthur F. Dorner, Frank V. Dunderman, Sidney C. Foster, Edson A. Freeman, Milton I. Friedman, J. P. Fulton, James W. German, John P. Goetz, Martin J. Gunter, Kenneth F. Hausfeld, John F. Henderson, John D. Hobensack, Everett F. Hurteau, F. A. Johnson, J. Walter Johnson, Harvey A. Karam, Keith C. Keeler, Walter A. Keitzer, F. Gerald Keyes, Erwin J. Kraker, James G. Kramer, Anastasius H. Kyriakides, Franklin N. Krichbaum, Joseph LaCamera, Louis A. Lame, Donald E. Leonard, Harry H. Leuchtag, Charles N. Long, George A. Lucas, Elmer J. Lukats, Paul G. Lukats, Edwin S. Lyon, Daniel W. Mathias, C. T. McCormish,

Don W. McCoy, Lawrence B. Mehl, Donald I. Minnig, Benj. Moorstein, Margaret H. Moore, William E. Moore, Howard O. Musser, Byron E. Neiswander, Carl C. Nohe, James C. Oberholtz, George A. Palmer, Philip I. Panitz, George K. Parke, Thayer L. Parry, Leonard V. Phillips, Marshall J. Pierson, R. E. Pinkerton, J. W. Pond, Walter R. Rechsteiner, John G. Repasky, Edwin A. Riemenschneider, Fowler B. Roberts, Ronald L. Ross, Louis Sheinin, Hazel P. Simms, Ernst J. Snyder, Fred F. Somma, Theo. E. Tetreault, Donald M. Traul, Joseph M. Ulrich, Thomas F. Ulrich, John W. Van Sise, James T. Villani, Edw. L. Voke, Frank M. Warner, Marshall R. Werner, James M. Whitworth, Louis A. Witzeman, Jefferson C. Woodbury, Robert E. Yeakley.

Trumbull County—Joseph N. Aceto, Edward E. Bauman, Leonard A. Blum, S. A. Brown, Maynard A. Buck, E. G. Caskey, Donald H. Chickering, Amanto P. D'Amore, Emil J. Datesh, Philip B. Giber, Joseph W. Kohn, Harold W. Law, Alfred F. Nelson, Paul Purvins, Joseph A. Ralston, Louis G. Ralston, Sigmund J. Shapiro, Alfred Smits, William G. Stover, George A. Sudimack,

Densmore Thomas, Robert L. Thomas, Edwin R. Westbrook, Albert L. Williamson.

Tuscarawas County—Jurgis Balciunas, Chester A. Bennett, Jay W. Calhoon, C. Raymond Crawley, Edgar C. Davis, Jr., Clark M. Dougherty, Philip T. Doughten, Joseph W. Hamilton, Daniel D. Hostetler, William E. Hudson, Dale K. Lindberg, H. Judson Reamy, Horace E. Reed, Robert E. Rinderknecht, William C. Roche, Arthur J. Stevenson, Herbert F. Van Epps, Harold F. Wherley, Samuel H. Winston, George D. Woodward.

Union County—Walter R. Burt, Fred C. Callaway, Bernard E. Ingmire, Herman E. Karrer, E. J. Marsh, May B. Zaugg, Paul R. Zaugg.

Van Wert County—Edwin W. Burnes, James R. Jarvis, F. A. McCammon.

Washington County—Kenneth E. Bennett, Charles C. Deamude, Ford E. Eddy.

Wayne County—Bernard M. Foster, Edward A. Gatz, Albert Burney Huff, Paul K. Jentes, James M. Knopp, Howard C. MacMillan, John P. Miller, Raymond J. Py, Jr., Ernest S. Redfield, Robert E. Reiheld, Richard W. Reiman, John M. Robinson, William F. Stewart.

Williams County—Paul G. Meckstroth, John R. Riesen.

Wood County—Sigmund A. Kosewick, Paul F. Orr, Roger A. Peatee, John V. Pilliod, Stewart J. Smith.

Wyandot County—Allen F. Murphy, Herschel A. Rhodes, Franklin M. Smith, H. K. Van Buren.

New Members of O. S. M. A.

The following are the names of the new members of the Ohio State Medical Association since April 1, 1956. The list shows the county in which they are affiliated, city in which they are practicing, or temporary address in cases where physicians are taking postgraduate work.

BUTLER COUNTY

Ronald W. Martz,
Hamilton
James A. Stewart,
Hamilton

FRANKLIN COUNTY

Lloyd William Barnes,
Columbus
Marvin Fish, Columbus
Werner E. Samlowski,
Columbus
Ludolph H. Van der Hoeven,
Columbus
Ernest R. Wilson,
Columbus

HAMILTON COUNTY

James W. Agna,
Cincinnati
Arik Brissenden,
Cincinnati
Fred A. Elkus, Cincinnati
Thomas G. Skillman,
Cincinnati
Jacques D. Wells,
Cincinnati
Ephraim Woll, Cincinnati
Philip C. Young,
Cincinnati

LORAIN COUNTY

Delbert L. Fischer, Lorain

LUCAS COUNTY

George O. Lewis, Toledo
Antonio Muto, Toledo
Steven Selmants, Toledo
Harold R. Stevens, Toledo

MAHONING COUNTY

Evelyn M. Bellaire,
Youngstown
Robert V. Bruchs,
Youngstown
Joseph J. Campolito,
Youngstown
Paul A. Dobson,
Youngstown
Robert B. McConnell,
Youngstown
Richard D. Murray,
Youngstown

MONTGOMERY COUNTY

Robert K. Finley, Jr.,
Dayton
Don E. Sando, Dayton
Erna Berzins, Dayton
Edward C. McGarry,
Dayton

MUSKINGUM COUNTY

Charles R. Donley,
Zanesville
Charles L. A. Wehr,
Zanesville

SANDUSKY COUNTY

Otmar H. Zeidner,
Fremont

WARREN COUNTY

Thomas E. Fox, Mason
Dale D. Hubbard, Franklin
Gilbert K. Ohlhauser,
Mason
Ray E. Simendinger,
Lebanon

Orientation in Rural Practice . . .

As Guests of Association, Senior Medical Students of Two Schools Hear Down-to-Cases Talks on Benefits of Non-Metropolitan Practice

HELD concurrently during the months of January, February and March were the Fifth Annual Ohio State Medical Association Special Talks for Medical Seniors at the Ohio State University College of Medicine, and the Second Annual series at the University of Cincinnati College of Medicine.

Sponsored by the Committee on Rural Health of the Association with the cooperation of the Student American Medical Association chapters and the administrations of both schools, the projects have the objective of stimulating interest of medical graduates in the general practice of medicine with emphasis on rural areas and small cities.

Six lectures are involved, and the speakers deal with advantages and disadvantages of "county seat" and rural practice along with practical information on the medical, business, and social aspects involved.

Lecturers for the Ohio State University Series were Drs. George A. Woodhouse, Pleasant Hill, member of the Judicial Council of the AMA and OSMA Second District Councilor; Edmond K. Yantes, Wilmington, chairman, OSMA Committee on Rural Health; Victor R. Frederick, Urbana, member OSMA Committee on Rural Health; and Robert E. Reiheld, Orrville, member, OSMA Committee on Rural Health. Dr. Robert D. Baer, Dalton, also appeared on the program at Ohio State.

The Cincinnati lecturers included Dr. Woodhouse, Dr. Yantes, and Dr. Richard R. Buchanan, Wilmington, member of the OSMA Committee on School Health.

Dinner meetings, held March 7 at the Ohio Union for the Ohio State University Group, and

March 8, at the Netherland Plaza Hotel for the University of Cincinnati students and wives, were addressed by Dr. Charles L. Hudson, then President of the Ohio State Medical Association, on the subject, "The Physician and His Medical Society." Dr. Yantes addressed the dinner meetings, on the topic, "The Physician and His Community."

Dr. Richard L. Meiling, then the Treasurer of the Ohio State Medical Association, served as toastmaster for the Ohio State University dinner meeting. Guests were: Mrs. Meiling; Dr. Chauncey D. Leake, assistant dean, Ohio State University College of Medicine, and Mrs. Leake; Mrs. Yantes; Dr. and Mrs. Frederick; Mrs. Margaret Colburn, assistant to the Dean; and Mrs. Dorothy Smith, secretary to the Assistant Dean of the College of Medicine.

Guests at the Cincinnati dinner were: Dr. Samuel A. Trufant, assistant dean of the college of medicine; Dr. Charles A. Sebastian, president of the Academy of Medicine of Cincinnati, and Mrs. Sebastian; Dr. Howard D. Fabing, president-elect of the Academy, and Mrs. Fabing; Dr. J. Robert Hudson, chairman, Committee on Public Relations of the Academy, and Mrs. Hudson; Dr. and Mrs. Buchanan; Mrs. Yantes; John Schlueter, president, Cincinnati Chapter, Student American Medical Association; Mr. Edward F. Willenborg, Executive Secretary of the Academy, and Mrs. Willenborg.

PRACTICAL SUBJECTS

Following is a gist of subjects covered in the lectures:

"Selecting a Place To Practice"—Needs of the community for a doctor or an additional doctor;



Dr. Frederick



Dr. Leake



Dr. Yantes



Seniors of OSU College of Medicine and Guests



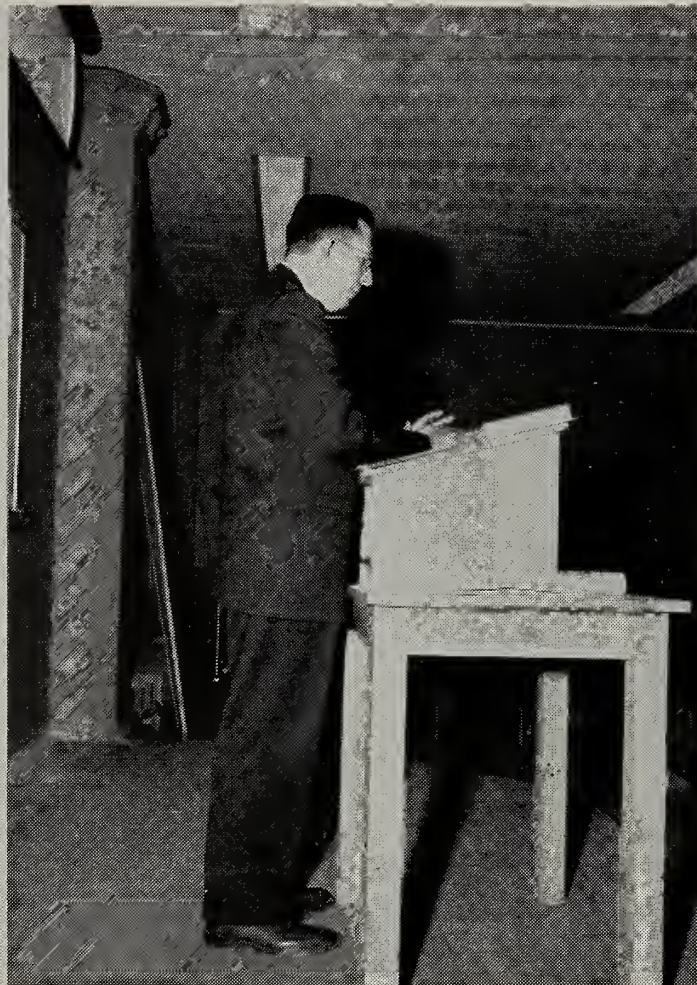
Dr. Hudson



Dr. Buchanan



Dr. Reiheld



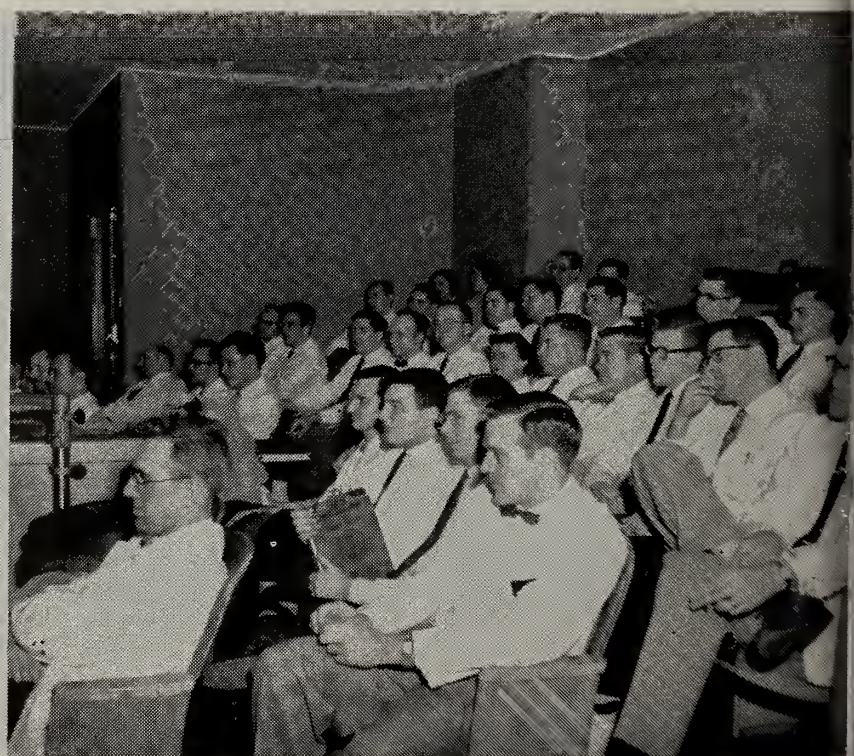
Dr. Woodhouse



Dr. Meiling



Cincinnati U Medical Seniors and Guests



Ohio State Group

community resources for the support of a doctor, its stability, etc.; professional problems, such as attitude of other doctors in area, cooperation of community groups, accessibility to outlying sections, etc.; personal and family problems, such as attitude of the wife, educational and church facilities for children, etc.

"Types of Practice Encountered" covered such practical considerations as the number of patients treated by the rural practitioner; kinds and economic status of patients; the need for referrals and availability of various specialists; work that the general practitioner can undertake himself; country calls; a typical day in the life of a rural practitioner, etc.

"Hospital Connections and Emergencies"—Increasing hospital facilities in rural communities; facilities open to the rural practitioner; hospital vs. home care; proximity to hospitals; consideration of efficiency of local hospital; rural medical and surgical emergencies encountered in rural practice.

The talks given by Dr. Woodhouse on the subject, "A General Practitioner Looks at Medical Ethics," were practical discussions of the high ideals and traditions of the profession entrusted to the physician in a rural community. Dr. Woodhouse, himself a rural practitioner for many years, has been accorded one of the highest honors that can be bestowed on a doctor, to be named a member of the Judicial Council of the American Medical Association.

"The Economics of Rural Practice"—Setting up practice in a rural community; office space available; housing; equipment; laboratory facilities; drug supplies; net and gross income as compared to that in metropolitan areas; use of time; types of practice, advantages and disadvantages of each; income from governmental agencies, etc.; the future of general practice.

Details concerning the series were worked out by Hart F. Page, OSMA Assistant Director of Public Relations.

Goodrich Company Will Hold Program for Its Doctors

Physicians working for the B. F. Goodrich Company have been invited to a two-day conference on health policies, June 14 and 15 at Brecksville, Dr. Rex H. Wilson, medical director for the company, announced.

Among physicians who will participate are: Dr. Wilson who will discuss the purpose of the industrial health conference, administration of the company disability allowance program and physical examinations; Dr. H. E. Reed, who will discuss the administration of the company's health insurance benefits, and the application of medical restrictions; Dr. G. H. Donnelly whose subject will be medical procedures in compensation cases.

Other company officials will discuss various phases of the company's health policies.

Need Medical Officer for New Marion Correctional Institution

THE Ohio Department of Mental Hygiene and Correction is in need of a Chief Medical Officer for the Marion Correctional Institution, Marion, a 1500 capacity medium-security institution. He will be in complete charge of all medical services and the 70-bed hospital. The position is more than just one of administration as it includes actual medical practice, including some surgery, although the medical officer would not be required to perform difficult or special surgery. The position will be open about July 1.

Contemplated starting salary for the position if someone who can perform surgery is employed is \$11,760, with a maximum of \$13,800. Starting salary for a physician not performing surgery would be \$9,640 with a maximum of \$11,760.

Physicians interested in the position should get in touch with Mr. M. C. Koblentz, chief, Division of Correction, Room 1211, Ohio Departments Building, Columbus 15, Ohio.

AMA To Close Printing Plant After 70 Years Operation

June 30 will mark the end of an era in American Medical Association history. That will be the date of the last *A.M.A. Journal* to be printed in the association's own printing plant. Beginning July 1, the *Journal* and the nine specialty journals printed by the A. M. A., will be printed by the McCall Corporation, Dayton, Ohio, which has printed *Today's Health*, the A. M. A.'s popular health magazine, since 1950.

In its nearly 70 years of operation, the shop printed enough Journals to circle the equator twice if they were laid end-to-end. The A. M. A. board of trustees decided to close the shop because the growth of the association's other activities and the rapid improvement of printing techniques have caused grave problems.

The journals will continue to be edited in the Chicago offices, but a production coordination office will be set up to work with the outside printers.

T. V. McDavitt, director of industrial and personnel relations, said that most publishers have found that it is more economical and efficient to "farm out" printing to a company which can keep its expensive high-speed multi-colored presses operating at full capacity. Not only will future issues of the journals be published in a print shop with adequate color presses and modern equipment, but the association's other important activities will now have room for necessary expansion.

OSMA Decision Upheld . . .

Actions of Local Medical Society and State Council in the Case Against Dr. Charles E. Bolinger Approved by AMA Judicial Council

THE Judicial Council of the American Medical Association has affirmed the action taken by The Council of the Ohio State Medical Association on December 11, 1955, ordering Charles E. Bolinger, M. D., Marysville, suspended from membership in the Union County Medical Society until January 1, 1960. Following disciplinary action taken by the Union County Medical Society, Dr. Bolinger appealed to The Council of the State Association and, later, appealed the decision of The Council to the AMA judicial body.

Following is the text of the opinion handed down by the Judicial Council of the AMA on April 27, 1956:

IN THE MATTER OF THE APPEAL OF DR. CHARLES E. BOLINGER TO THE JUDICIAL COUNCIL OF THE AMERICAN MEDICAL ASSOCIATION

There has been submitted to the Judicial Council of the American Medical Association for determination and decision the appeal of Dr. Charles E. Bolinger from the proceedings and orders of the Union County Medical Society and the Ohio State Medical Association. The action of the State Association was an order suspending Dr. Bolinger from membership in the Union County Medical Society from December 17, 1954 until January 1, 1960.

At its meeting on March 22, 1956, the Council considered the briefs and heard the oral arguments of counsel for Dr. Bolinger, the Union County Medical Society and the Ohio State Medical Association. Dr. Donaldson was absent and Dr. Woodhouse was excused from the case at his own request. The remaining members of the Council, constituting a quorum, have made a thorough study of the entire record filed in connection with the appeal, and have carefully considered the briefs and oral arguments presented.

At a special meeting convened this 27th day of April, 1956, the Judicial Council reached the decision stated in this opinion.

QUESTIONS BEFORE THE JUDICIAL COUNCIL

In his Statement of Appeal filed with the Judicial Council Dr. Bolinger has alleged thirteen errors of law and procedure in the actions of the Union County Medical Society and the Ohio State Medical Association. These assignments of error contend:

Assignment (a)—That the second Board of Censors of the Union County Medical Society did not have jurisdiction to hear charges for a number of reasons.

Assignments (b), (c), and (d)—That the evidence presented was not sufficient to sustain the charges upon which the actions of the county and state medical societies were predicated.

Assignments (e) and (f)—That "required efforts" at conciliation were not attempted by either the county or state society.

Assignment (g)—That the State Association had no authority to modify the order of the Union County Medical Society.

Assignment (h)—That the decision of the State Association is without effect since it was not signed by certain officers of the Association.

Assignments (i), (k) and (m)—That the findings by the county and state society were in error and were "arbitrary," "contrary to law," and deprived the Appellant of a property right.

Assignment (j)—That the County Association considered the matters alleged against the Appellant as one charge, whereas the State Society considered them as separate charges.

Assignment (l)—That certain members of the County Medical Society were prejudiced against the Appellant and planned his expulsion from the Society before formal charges were filed.

COMMENTS

The attention of all parties to the proceedings is invited to Chapter XI, Section 10 of the By-Laws of the American Medical Association which outlines the duties and jurisdiction of the Judicial Council. Subsection (3) provides in part:

"The Council shall have appellate jurisdiction in questions of law and procedure but not of fact. . ."

By virtue of this limitation of authority, certain of the allegations of error presented by the Appellant in this case may not properly be considered.

It is the opinion of the Judicial Council that Assignments (b), (c) and (d) in dealing with the sufficiency of proof presented at the county and state proceedings raise a question of fact beyond its jurisdiction. The evidence accepted by the State Association as sufficient proof of Charges 1, 2, 4 and 7 against the Appellant appears to the Council to be competent and relevant.

Assignments (j), (k), (l) and (m) refer to matters which are irrelevant, argumentative, or concerned with questions not properly before or within the jurisdiction of the Council.

With respect to the questions raised in the other assignments of error, it is the opinion of the Council that the second Board of Censors

of the Union County Medical Society was properly constituted and did have jurisdiction in the proceedings under consideration. It further appears that they operated in substantial compliance with the rules and regulations of the Society in a fair and impartial manner.

The requirements of the By-Laws of the County and State Society, with respect to efforts at conciliation, are worded in such broad and indefinite terms that they amount to recommendations rather than mandatory requirements. In any event, the record in this case reveals that sufficient efforts were made to comply with such terminology as "so far as possible and expedient."

The remainder of the assignments of error deal with the authority of the State Society and the form and nature of the decision rendered by that body. The allegation with respect to the lack of proper signatures on the final order of the State Society does not appear to the Council to be of sufficient consequence to result in any prejudice to the Appellant. Further from the Council's reading of the Constitution and By-Laws of the Union County Medical Society it is not felt that the decision of the State Association "extended the period of deprivation of rights" of Dr. Bolinger nor was it arbitrary or in violation of law and the County Constitution and By-Laws.

The last point raised questions the right of the State Association to modify the decision of a component county society. This question was presented recently to the Judicial Council in the Appeal of the Yuma County Arizona Medical Society. In its decision in the case on February 9, 1955, the Council stated, in part:

"... the state association did have, in the absence of specific provision to the contrary, the right to modify the punishment imposed by one of its component societies. It based its conclusion on two grounds: (1) a right of appeal would be sterile and of no value whatsoever if an inherent right did not exist to affirm or reverse the decision appealed from, and that the right to reverse includes the right to modify; and (2) the state association being the parent and chartering body possesses the right to supervise the actions of its component societies and this right, being inherent by nature in the constituent association, is limited only by the restrictions found in its constitution, by-laws, rules, and regulation. Thus, if the right of appeal to the state association is granted without limitation or restriction, it must be presumed that the state has the right to act on appeal as its judgment dictates."

DECISION

The record filed with the Judicial Council does not disclose that there were any contested errors or irregularities in the proceedings before the

Union County Medical Society or the Ohio State Medical Association which were sufficiently consequential to prevent him from having a fair and impartial trial.

For these and for the other reasons stated above, it is the decision of the Judicial Council that the Order of Suspension of the Ohio State Medical Association of December 11, 1955, be affirmed, and that "Dr. Bolinger stand suspended from membership in the Union County Medical Society, and from all rights, prerogatives and privileges pertaining thereto, from and after December 17, 1954, to and until January 1, 1960."

Cincinnati Academy To Celebrate Centennial Next March With Public Exhibits and Lectures

On March 5, 1957, the Academy of Medicine of Cincinnati will be exactly 100 years old. Members of the Academy have already initiated a number of projects which will culminate in a huge celebration of this memorable birthday.

Dr. Howard D. Fabing, who will be president of the Academy in 1957, has announced that Cincinnati's Music Hall will be the scene of a Centennial Exposition. Exhibits will tell the story of 100 years of medical and health progress in Cincinnati and in the nation. The exhibits will be shown to the public with no charge for admission.

Another facet of the anniversary will be a series of public lectures by national authorities and the showings of selected medical and health motion pictures at the Music Hall Auditorium during the centennial week, which will last from February 27 through March 5.

A Centennial Convocation of the Academy of Medicine, to which dignitaries in the fields of science, education, and statecraft will be invited, will be held in the Auditorium of the Music Hall on the final evening of the celebration.

Conducted tours of the exhibition hall for school children and other special groups will be scheduled with the members of the Woman's Auxiliary to the Cincinnati Academy of Medicine acting as guides.

Miniature "preview exhibits" to herald the exposition will be displayed throughout the city in advance of the anniversary week, to build public interest in the event.

Medical Officers Get Pay Hike

Because the President signed the military career incentive bill promptly, physicians in uniform received their pay raises starting May 1. The minimum boost (after two years' service) is \$50 per month, the maximum (after 10 years) \$150.

In Our Opinion:

Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

BE SURE OF FACTS ABOUT APPLICANT

Within the next few weeks, practical nurses in Ohio may be bringing their applications for the practical nurse license to Ohio physicians for certification of practice as a practical nurse and certification of good moral character.

The Ohio law and Board rules provide that an experienced practical nurse who is not a graduate of a school of practical nursing may be licensed by waiver of requirements without and with examination, providing she

1. Resides in Ohio and practices in Ohio as a practical nurse and
2. Can produce a certified statement from two licensed physicians of Ohio or two registered nurses of Ohio, or one of each, that she
 - a. Has worked with each of them and has been practicing nursing as a practical nurse for more than two years immediately prior to the date of the application; and
 - b. Is competent and of good moral character.

Since it is important that only persons who have had the required amount of experience are granted certificates, physicians should follow the letter of the law, as set forth above, in executing certified statements for applicants.

POOR ETHICS IN HANDLING V. A. STORY

A month ago the House Veterans Committee announced that it had discovered some dishonesty and irregularities on the part of physicians and dentists participating in the so-called home-town medical care program for disabled veterans. Big black streamer headlines concerning the story appeared in some Ohio newspapers. Readers must have gained the impression that many members of the medical and dental professions were parties to widespread fraud and corruption. Actually, according to Ohio Veterans Administration officials, only four physicians and eleven dentists in the entire State of Ohio were accused; some of them were guilty of so-called "honest" mistakes.

Obviously, physicians and dentists who play fast and loose with the V. A. or any other agency, or any individual patient, should be disciplined. No punches should be pulled on that.

However, in our opinion, the newspapers which played up this story out of proportion to its importance and the number involved, did the medical and dental professions a grave injustice. The newspaper profession certainly can't be very proud of this episode.

Also, those who made the announcement to the

press were equally guilty of poor tactics. By failing to name names, they cast reflections on the total memberships of both professions. In other words, any physician or any dentist could have been one of the four or eleven referred to in the news releases. The next time the government, or Congress, or what-have-you decides to inform the public about the irregularities of physicians or dentists, and has the proof to back up their charges, they should name names and not indict all physicians and all dentists, by inference.

BUSINESS TRIPS AND YOUR INCOME TAX RETURN

Internal Revenue Service has issued a memo, Rev. Rule 56-168, directing its agents to check carefully deductions for costs of business trips, attending conventions, etc.

Cost of personal recreation, sightseeing, etc., which is not basically a part of the business trip or convention is not deductible.

If wife goes on trip, her share of the expenses is not deductible unless there was a valid business reason for her going—which is not the case in most instances.

So, better check on this ruling and discuss the matter with the officials when submitting deductions for so-called business trips.

COSTS ONE THING; PAYMENTS ANOTHER

Much has been said and written lately about possible legislation to control hospital costs in Ohio. Those who get into this act should be careful as to the terms used. There is a difference between "hospital costs" and the amounts paid for hospital services rendered.

As hospital authorities have pointed out: "No one can regulate hospital costs through legislation, because no one can pass a law regulating sickness . . . Cost of giving care is based largely on the cost of labor, since hospital salaries account for more than two-thirds of hospital costs. Hospitals do not determine rates for labor or costs of food and supplies, any more than does industry. Hospital wages will continue to increase with economic trends."

What amounts shall be paid to hospitals by governmental agencies, insurance companies, and others who may be third-parties in the arrangement can, of course, be regulated either by legislation or executive order.

But, legislative or executive action will not—cannot—regulate "hospital costs." In the end,

voluntary, nonofficial action is the best method of attacking hospital costs. Voluntary cooperation on the part of patients, physicians, hospital authorities and others (who may be paying the bill) to eliminate abuses, unnecessary utilization, frills, etc., can be undertaken—should be undertaken. It's the only practical way of trying to do something to meet those causes for rising hospital costs which are not actually a result of today's inflated economy.

HERE'S A PRESENT FOR YOUR OFFICE GAL

A 350-page manual for the modern physician's "Girl Friday" should be available in your favorite book store.

Entitled *The Office Assistant*, the book contains suggestions for more efficient procedures and methods of handling nearly every phase of medical office work. Its contents are valuable to anyone employed in a doctor's office—secretary, receptionist, nurse, bookkeeper, technician. The book was planned to save the doctor time, money and a vast amount of explanation in the training of an efficient office aide.

Authors are: Portia M. Frederick, Instructor in Medical Office Assisting, Long Beach College, California, and Carol Towner, director of special services, A. M. A. Public Relations Department.

The book will sell for \$5.75 and is being published by W. B. Saunders Company, West Washington Square, Philadelphia (5).

This illustrated reference manual answers such questions as: how to care for instruments and supplies, how to write a series of collection letters, how to keep a narcotics inventory, how to prepare a patient for various types of examinations, and how to prepare accident and health insurance forms. About half the chapters deal with the medical assisting side of the office and the remainder with the business side.

CHECK BEFORE PICKING A COLLECTION AGENCY

The Ohio Supreme Court recently decided the case of Housh, appellee, v. Perth, appellant, et al, in favor of the appellee, the plaintiff.

The case is of interest to physicians. First, it arose over an attempt by a collection agency to collect a physician's bill from the plaintiff, a school teacher. In the second place, the story emphasizes how a physician can easily create bad public relations for himself by selecting to do his collecting an agency which apparently thinks use of the big stick is the only way to achieve its ends.

The charges underlying the case and the reasoning behind the court's verdict are set forth in the following syllabus:

1. The right of privacy is the right of a person to be let alone, to be free from unwarranted publicity, and to live without unwarranted inter-

ference by the public in matters with which the public is not necessarily concerned.

2. An actionable invasion of the right of privacy is the unwarranted appropriation or exploitation of one's personality, the publicizing of one's private affairs with which the public has no legitimate concern, or the wrongful intrusion into one's private activities in such a manner as to outrage or cause mental suffering, shame or humiliation to a person of ordinary sensibilities.

3. A creditor has a right to take reasonable action to pursue his debtor and persuade payment.

4. Such action is not reasonable where a creditor or his representative initiates a campaign to harass and torment the debtor, telephones the debtor six or eight times every day at her home and place of employment—some of the calls as late as 11:45 p. m.—over a period of three weeks, telephones the debtor's superiors and informs them of the debt, and calls the debtor at her place of employment three times within a period of 15 minutes with a resultant threat of loss of employment.

Better check before engaging a collection agency. Its tactics, if wrong, can hurt you.

MORE FACTS, FEWER RUMORS DESIRABLE

Following is a typical example of how rumors and statements which are not supported by facts have complicated the polio vaccine problem, which in itself has been confusing enough without assists from the misinformed. The story involves Congressman Thomas L. Ashley, Toledo. It is told by the *Toledo Blade*, via its Washington Bureau, as follows:

Toledo Blade Bureau

WASHINGTON, April 12—Surgeon General Leonard A. Scheele today told Rep. Thomas L. Ashley that he doubts if "any significant amount" of outdated polio vaccine has been administered to Toledo children.

Dr. Scheele made this observation in a letter in reply to complaints from Mr. Ashley concerning a shipment of 14,202 doses of vaccine sent to the Toledo Health Department last winter which bore an expiration date of Feb. 4 and another shipment of 9,684 doses which had an expiration date of Feb. 19.

Mr. Ashley charged that the vaccine had been sent to Toledo late in January and that much of it presumably had been administered after its expiration date.

In his letter today Dr. Scheele says records of the Ohio State Health Department show that the shipments to Toledo were made on Dec. 8, 1955, and that nearly 90 per cent of it had been administered before Feb. 1 of this year.

Dr. Scheele said there is insufficient evidence as yet as to the potency of the polio vaccine beyond its 6-month expiration date.

"In brief, although it remains safe, it is possible that its effectiveness may be reduced," the letter said.

"In view of the very small amount of vaccine, however, which has reached its expiration date prior to utilization, it is doubtful that any significant amount of vaccine has been administered after its expiration date."

It appears quite obvious that the facts and the complaints, enumerated above, did not jibe. Facts speak for themselves.

In Memoriam . . .

Charles S. Amidon, M. D., Harlingen, Texas; Eclectic Medical College, Cincinnati, 1902; aged 79; died April 15; former member of the Ohio State Medical Association. Dr. Amidon practiced for 30 years in Cincinnati before he moved to Texas about 20 years ago. He served for many years as head of the eye, ear, nose and throat department at Bethesda Hospital and was also vice-president of the hospital staff. He is survived by his widow, Dr. Vivien Miller Amidon; two sons and two daughters.

Leslie L. Bottsford, M. D., Akron; University of Michigan School of Medicine, 1914; aged 68; died April 22; member of the Ohio State Medical Association and the American Medical Association; diplomate of the American Board of Obstetrics and Gynecology. After doing residency work at Johns Hopkins, Dr. Bottsford returned to Ann Arbor and remained there for several years. He had been a practicing physician in Akron for 36 years. Religious affiliation was with the Congregational Church. His widow survives.

Amon E. Canfield, M. D., Toledo; Starling Medical College, Columbus, 1914; aged 66; died April 15; member of the Ohio State Medical Association. A resident of Toledo for most of his life, Dr. Canfield had practiced there since 1915, and for most of that time was physician for the New York Central System. He was a member of the Foresters Lodge. Surviving are his widow and a daughter.

Dwight R. Canfield, M. D., Perrysburg; Toledo Medical College, 1907; aged 84; died April 20; member of the Ohio State Medical Association and the American Medical Association. A native of Wood County, Dr. Canfield taught school there for several years before he went to medical college. He began practicing in 1907 and continued until his retirement in 1952. He was a former mayor of Perrysburg, served two terms as county coroner and served on the local board of education. He published several books on local history; was a member of the Odd Fellows Lodge and the Methodist Church. Two daughters and a son survive.

Robert B. Chamberlin, M. D., Twinsburg; Western Reserve University School of Medicine, 1904; aged 75; died April 24; member of the Ohio State Medical Association and the American Medical Association. Dr. Chamberlin's family moved to Twinsburg when he was 15 years old. Upon completion of his medical education, he returned there and practiced for 52 years, receiving the State Association's 50-Year Award, upon completion of a half century of service. He was active in community groups, having served as president of the Rotary Club; he was a past-

master of the local Masonic Lodge and a 32nd Degree Mason. Over the years he organized a local band, managed a baseball team, took turns serving as game warden, justice of the peace and Sunday School superintendent in the Congregational Church. He also practiced dentistry in earlier years, being a graduate of the Western Reserve College of Dentistry. Survivors include his widow and a son, Dr. Glen R. Chamberlin, also of Twinsburg.

Valentino B. DiLoreto, M. D., Steubenville; medical degree from Regia University of Naples, Italy, 1905; aged 76; died March 31; member of the Ohio State Medical Association and the American Medical Association. After graduate training at the University of Florence, Dr. DiLoreto came to the United States and settled in Steubenville in 1906. Last year he was honored at a community testimonial sponsored by the Jefferson County Medical Society and was presented the 50-Year Pin of the Ohio State Medical Association. He was a member of the Catholic Church, a Grand Venerable of the Ohio Organization of Sons of Italy, a member of the Knights of Columbus and the Knights of St. George. Survivors include his widow, a son, a daughter, a step-son and a step-daughter.

Claude B. Estle, M. D., New Albany; Ohio State University College of Medicine, 1912; aged 71; died April 4; member of the Ohio State Medical Association through 1955. Dr. Estle had been a practicing physician in the New Albany area for 44 years and was active in numerous community affairs. Affiliations included memberships in the Methodist Church and the Masonic Lodge. Survivors include his widow, a son, a daughter and two brothers.

Eli S. Holmes, M. D., Plain City; Starling Medical College, Columbus, 1897; aged 84; died March 30; former member of the Ohio State Medical Association. Dr. Holmes began his practice in Plain City in 1898 and continued in practice until about two years ago. He was a recipient of the State Association's 50-Year Emblem. A 50-year Mason, he was a director of the Farmers National Bank and was active in numerous community affairs. He is survived by a foster daughter.

Lloyd B. Johnston, M. D., Cincinnati; Johns Hopkins University School of Medicine, 1922; aged 62; died April 5; member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Surgeons; diplomate of the American Board of Surgery. A physician of long standing in Cincinnati, Dr. Johnston was one of the founders of the Ohio State Surgical Association and was chief of the surgical section at Good Samaritan

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DOSAGE • The daily *adult* dose is three to five Nilevar tablets (30 to 50 mg.) but up to 100 mg. may be administered. For *children* the daily dose is 1 to 1.5 mg. per kilogram of body weight. Individual dosages depend on need and response to therapy. Nilevar is available in 10 mg. tablets. G. D. Searle & Co., Research in the Service of Medicine.

INDICATIONS:

Nilevar is indicated in the vast area of surgical, traumatic and disease states in which protein anabolism is desirable for hastening recovery. The specific indications are:

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6. Domiciliary care of decubitus ulcers.
7. Care of premature infants.



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SEARLE

Hospital. He was a former vestryman of the Episcopal Church. Two sons survive.

Peter A. Kemper, M. D., Germantown; Eclectic Medical College, Cincinnati, 1903; aged 79; died April 12; member of the Ohio State Medical Association and the American Medical Association. Dr. Kemper had been a practicing physician for more than a half century and had been honored with the 50-Year Pin of the Ohio State Medical Association. All but two years of his practice was in the Germantown area where he moved in 1906 from Vandalia, W. Va. Dr. Kemper was active in a number of community affairs; he was a member of the Methodist Church, several Masonic bodies, the Eastern Star and the local Chamber of Commerce. Survivors include his widow; a son, Dr. Robert Kemper, of Chicago; a daughter; three brothers, including Dr. V. H. Kemper, of Dayton, and Dr. James Kemper, Morrow dentist; also six sisters.

Delfhis Robert Milliette, M. D., Anna; Cincinnati University College of Medicine, 1903; aged 83; died April 16; member of the Ohio State Medical Association and the American Medical Association. Dr. Milliette lived virtually all of his life in the Anna community where he taught school before studying medicine. He returned there to practice in 1903, but his interest in education continued and he served for 48 years on the local board of education and 17 years on the Shelby County board of education. In 1947 the community paid honor to Dr. Milliette for his service to the community, and in 1953 the Ohio State Medical Association honored him with the 50-Year Pin. His survivors include a son, Dr. Gerald Milliette, Milwaukee, Wisc., and two daughters.

Frederick E. Mitchell, M. D., Bellevue; Ohio State University College of Medicine, 1943; aged 38; died April 1. A native of Bellevue, Dr. Mitchell returned to practice there after doing residency work in Columbus, and serving in the Army Medical Corps. He was active in a number of local affairs, being a member of the Elks Lodge, the Kiwanis Club and the Chamber of Commerce. Surviving are his widow, a step-daughter, two brothers and a sister.

John D. Nourse, M. D., Shaker Heights; Western Reserve University, 1916; aged 64; died April 6; former member of the Ohio State Medical Association; diplomate of the American Board of Pediatrics. A practicing physician for many years in Cleveland, Dr. Nourse was on the staff of the Babies' and Children's Division of University Hospitals for 30 years; also for many years he was medical director of the Children's Services for the Welfare Federation. During World War I, Dr. Nourse served with the Army Medical Corps. He was a member of Delta Tau Delta, Nu Sigma Nu and Alpha Omega Alpha;

also a member of the Arts Club and the Professional Men's Club. Surviving are his widow, a daughter, two sons and a brother.

Stanley J. Pater, M. D., Hamilton; St. Louis University, College of Medicine, 1926; aged 55; died April 15; member of the Ohio State Medical Association and the American Medical Association. A native of Hamilton, Dr. Pater returned there to practice upon completion of an internship in Cincinnati. In addition to his private practice, he was examiner for two insurance companies. He was a member of the Catholic Church and the Order of Foresters. Surviving are his widow, a daughter and three brothers including Dr. Walter Pater and Dr. Joseph Pater, both of Hamilton.

Ralph E. Ramey, M. D., Blacklick; Ohio State University College of Medicine, 1928; aged 57; died April 10; member of the Ohio State Medical Association and the American Medical Association. Dr. Ramey was the third generation in a family line of physicians. His father was Dr. John H. Ramey and his grandfather Dr. Miles E. Ramey, both late of Rock Camp; and he was the son-in-law of the late Dr. E. I. Stanley, of Albany. Dr. Ralph Ramey practiced for 17 years in Bexley, but gave up general practice because of his health and became surgeon for the Army Columbus General Depot. He was a veteran of World War I and during World War II served as medical examiner for the Army. Affiliations included memberships in the Masonic Lodge, the American Legion, the Presbyterian Church, and Nu Sigma Nu. Surviving are his widow, three sons, two daughters and a sister.

Austin C. Roberts, M. D., Loveland; Starling Medical College, Columbus, 1890; aged 93; died April 2; former member of the Ohio State Medical Association. Dr. Roberts began his professional career in Harveysburg and moved to Morrow in 1893. In 1922 he moved to Wilmington and continued in practice until his retirement about 10 years ago. He was a member of the Masonic Lodge, the Odd Fellows Lodge, Knights of Pythias and the Presbyterian Church. Three daughters survive.

Thomas Morris Ruskin, M. D., Wapakoneta; Ohio State University College of Medicine; aged 29; died April 28. Dr. Ruskin began his practice in Wapakoneta after he completed an internship in Springfield. He was there only a short time when he became seriously ill. A veteran of World War II, he was a member of the Catholic Church and the Kiwanis Club. Surviving are his widow, three children, his mother and a step-sister.

Max Shaweker, M. D., Dover; Northwestern University School of Medicine, 1914; aged 67; died April 17; member of the Ohio State Medical Association and the American Medical Association; member of the American Society of Clinical

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Pathologists and diplomate of the American Board of Pathology. A native of Tuscarawas County, Dr. Shaweker practiced for many years in Dover where he maintained a private practice in pathology and served the Dover Hospital. Later he became chief pathologist for Mercy Hospital in Canton and was identified with other Canton and Massillon hospitals, while maintaining his home in Dover. He was a member of the Masonic Lodge, the Elks Lodge, and the Moravian Church. Surviving are his widow, four daughters, and a sister.

William G. Siddall, M. D., Alliance; University of Western Ontario, Canada, 1915; aged 65; died April 13; former member of the Ohio State Medical Association; Fellow of the American College of Surgeons. Dr. Siddall practiced for nine years in Watford, Canada, and a year in Cleveland before he moved to Alliance about 30 years ago. He was active in a number of organizations, including the Rotary Club, the Elks Lodge, the Masonic Lodge, and the Presbyterian Church. Surviving are his widow, a son, two daughters, two brothers and three sisters.

Howard Lee Smallman, M. D., San Rafael, Calif., University of Michigan School of Medicine, 1914; aged 63; died April 2; member of the Ohio State Medical Association, the American Medical Association and the American Association of Industrial Physicians and Surgeons. Dr. Smallman maintained his practice in Barberton for many years before he moved to California. He was a veteran of World War I, having served as Captain in the Medical Corps. Surviving are his widow, a son and a daughter.

Charles Russel Smith, M. D., Harrisburg; Starling Medical College, Columbus, 1894; aged 83; died April 6 in a traffic accident. Dr. Smith had been a practicing physician in Harrisburg for more than 60 years, and was still in practice at the time of death. He was a member of the local school board for many years and was interested in cattle raising. Surviving are a daughter and a brother.

Leon G. Tedesche, M. D., Miami, Fla.; Cincinnati Medical College, 1905; aged 77; died April 29; member of the Ohio State Medical Association, the American Medical Association and the American Association of Industrial Physicians and Surgeons. A native of Cincinnati, Dr. Tedesche served all of his professional career there, moving to Florida after his retirement. He was honored last year with the 50-Year Pin of the State Association. In former years he lectured at the Cincinnati College of Pharmacy, the Cincinnati Dental College and the old Cincinnati Eclectic Medical College. For years he served as director of the Industrial Emergency Hospital and was director of the West End Industrial Dispensary from 1930 to 1952. He was also a former bacteriologist for the Milk Commission. In addition to his professional work, Dr. Tedesche

was active in the training programs of the YMCA and the Boy Scouts. He was a 32nd Degree Mason and a member of the American Philatelic Society. His only survivor is a niece who is his adopted daughter.

Edward M. Wright, M. D., Warsaw and Coshocton; Eclectic Medical College, Cincinnati, 1896; aged 82; died April 25; former member of the Ohio State Medical Association and past-president of the Coshocton County Medical Society. A recipient of the State Association's Fifty-Year Award, Dr. Wright began his practice in the Coshocton area in 1896. In recent years he had been making his home in nearby Warsaw. He was active in numerous local organizations and community affairs. Activities and offices had included membership on local and county boards of education; service as county coroner; past-president of the Ohio State Eclectic Medical Society; past-president of the local Rotary Club; service as chairman of the Selective Service Board and the local health board. He was a 32nd Degree Mason and a member of the Christian Church. Surviving are his widow, a son, a sister and a brother.

Obstetrics and Gynecology Board Now Accepting Applications

Applications for certification by American Board of Obstetrics and Gynecology for the 1957 Part I examinations are now being accepted. Candidates are urged to make such application at the earliest possible date. Deadline date for receipt of applications is October 1, 1956.

All candidates for admission to the examinations are required to submit with their application, a plain typewritten list of all patients admitted to the hospitals where they practice, for the year preceding their application or the year prior to their request for reopening of their application.

Application for re-examination, as well as requests for resubmission of case abstracts, must be made to the secretary prior to October 1, 1956.

Current bulletins outlining present requirements may be obtained by writing to the Secretary's office: Robert L. Faulkner, M. D., American Board of Obstetrics and Gynecology, 2105 Adelbert Road, Cleveland 6, Ohio.

Fort Steuben Academy

The subject, "Tumors of the Neck," was discussed at the May 8 dinner meeting of the Fort Steuben Academy of Medicine held in the Ft. Steuben Hotel, Steubenville. Guest speaker was Dr. Robert L. Schmitz, of the Department of Surgery, Loyola University, Chicago. Local speaker was Dr. Paul Mesaros, of Steubenville.

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Supplied: Tablets, 25, 50, and 100 mg., bottles of 50 and 500; 200 mg., bottles of 500. Injection, 50 mg. per cc., vials of 2 and 10 cc.

1. Seifter, J., et al.: To be published. 2. Fazekas, J.F., et al.: M. Ann. District of Columbia 25:67 (Feb.) 1956. 3. Mitchell, E.H.: J.A.M.A. In press.



Philadelphia 1, Pa.

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Somewhat Larger Supply of Polio Vaccine Is Coming into Ohio

Although the supply is still limited, Salk polio vaccine has been coming into Ohio in somewhat increasing amounts. During the period April 18 to May 18, the Ohio Department of Health received 526,914 cc., in seven allotments. Of this amount, 466,029 cc. went into commercial channels and one lot of 60,885 cc. was purchased by the Department for distribution to health agencies.

That amount brings the total of vaccine received in Ohio from August 1955 through May 18, 1956, to 2,129,136 cc., of which 1,451,846 cc. went into commercial channels and 677,310 was purchased for agency distribution.

The increased percentage put into commercial channels recently has gradually increased the ratio of commercial vaccine to agency distributed vaccine. The percentage is a little less than 69 commercial to 31 agency. Actually the ratio for the past month has been well below the 20-80 ratio set last year by the Ohio Department of Health as a goal, and helps bring the year's total nearer that goal.

The Ohio Department of Health has previously announced the necessity of giving one shot of vaccine to each child in the 1-15 age group and pregnant women before any additional second shots are given, as long as the supply is limited. (See April issue of *The Journal*.)

In line with the 20-80 ratio goal, Dr. Ralph E. Dwork, director of the Ohio Department of Health, on May 17 issued a memorandum to local health commissioners, requesting that they requisition vaccine for the 11-15 year old group in their districts. The text of the memorandum follows:

"With the extension of the age range of priority to include children through 15 years and the recommendation that only one injection be given to this group at the present time as announced in Poliomyelitis Memorandum No. VI dated April 12th, this department plans to purchase additional vaccine as it becomes available on the market.

"When this is possible, allocations will be made to all health departments who want vaccine for this extended age group. The amount to be furnished will be based on one cc. for 20 per cent of the children between the ages 11 through 15.

"As was done during previous allocations, except where the amount of vaccine is relatively small, distribution will be made from each of our district offices on specified dates. Where the number of cc's is small, shipment will be made by registered mail.

"Since you might have been conducting your inoculation program through the local school

for CHILDREN with EDUCATIONAL and ADJUSTMENT PROBLEMS

- ... a private resident school for children of average or superior intelligence whose psychological difficulties impair their learning abilities and school progress.
- ... enrolling children from seven to fourteen years of age. Coeducational. Small classes. Remedial reading. Brochure on request.
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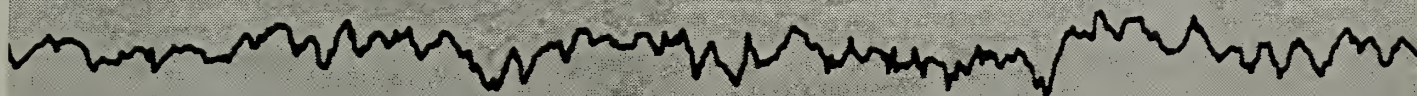
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5923 Pandora Ave., Tel. Redwood 1-0657
CLEVELAND Office: J. R. Ticknor, Rep.,
4023 Ellison Road, South Euclid 21,
Telephone Evergreen 2-1160
If no answer, call Superior 1-9616
COLUMBUS Office: R. G. Woehr, Rep.,
116 Blenheim Road, Tel. AMherst 2-6200
If no answer, call CAPital 4-4116

WHAT IS THE DIFFERENCE BETWEEN A TRANQUILIZER AND A SEDATIVE?

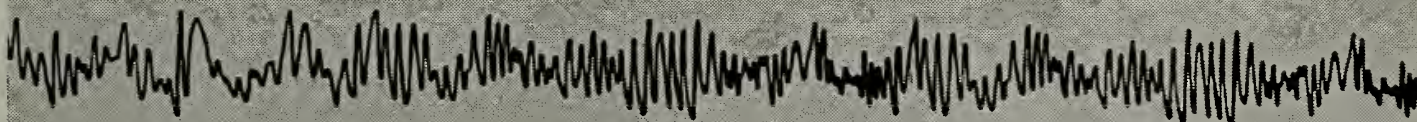
*Comparison of the effect of Raudixin (tranquilizer) and a
barbiturate (sedative) on the cortical electroencephalogram*



No drug.



After Raudixin. E. E. G. not altered.



After barbiturate. Typical "spindling" effect.

Because barbiturates and other sedatives depress the cerebral cortex, the sedation achieved is accompanied by a reduction in mental alertness.

Raudixin acts in the area of the midbrain and diencephalon, and does not depress the cerebral cortex. Consequently, the tranquilizing (ataractic) effect achieved is generally free of loss of alertness.

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Squibb Whole Root Rauwolfia Serpentina

DOSAGE: 100 mg. b.i.d. initially; may be adjusted within a range of 50 mg. to 500 mg. daily. Most patients can be adequately maintained on 100 mg. to 200 mg. per day.

SUPPLY: 50 mg. and 100 mg. tablets; bottles of 100, 1000 and 5000.

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system, there might be a possibility that it cannot be continued during the summer months.

"In order that allocations can be made as soon as more vaccine is purchased, which we hope will be within the next three weeks, it is requested that this office be notified if you are desirous of receiving an allotment of poliomyelitis vaccine for your 11-15 year age group. If we do not hear from you by May 28th, we will assume that you are not interested in additional vaccine at this time."

Pamphlets on Health Insurance Being Sent to Physicians

The first of a series of three new pamphlets on health insurance sold by insurance companies is being sent to physicians by the Health Insurance Council. The Council is a confederation of insurance trade associations.

The three pamphlets, which were prepared especially for physicians, contain information particularly helpful to physicians in answering patients' questions about health insurance.

Title of the first pamphlet in the series is: "Nature and Types of Health Insurance as Issued by Insurance Companies." The other two, on fundamentals of health insurance, and on buying and owning health insurance, respectively, will be distributed later.

Doctors failing to receive copies of these pamphlets by mail may obtain them from the Health Insurance Council, 488 Madison Avenue, New York 22, New York.

Chapters in the first pamphlet cover the following subjects:

- Basic Concepts of Health Insurance
- Objective and Value of Health Insurance
- Group Health Insurance and Individual Policies
- Cancellable and Noncancellable Insurance
- Health Insurance Types and Coverage
- Health Benefits Beyond the Scope of Health Insurance
- Loss-of-Income Protection
- Hospital Expense Protection
- Surgical Expense Protection
- Regular Medical Expense Protection
- Major Medical Expense Protection
- An Illustration of Policy Benefits
- Health Insurance Benefit Payments.

Cincinnati Area General Physicians

In collaboration with the University of Cincinnati College of Medicine, the Southwestern Ohio Society of General Physicians presented a symposium on "Cancer Detection in General Practice" on April 22. Taking part in the presentations were the following members of the College faculty: Dr. Charles Barrett, associate professor of Radiology; Dr. Charles Blase, instructor in otolaryngology; Dr. Edward A. Gall, professor of pathology; and Dr. Douglas Graf, clinical instructor in gynecology.

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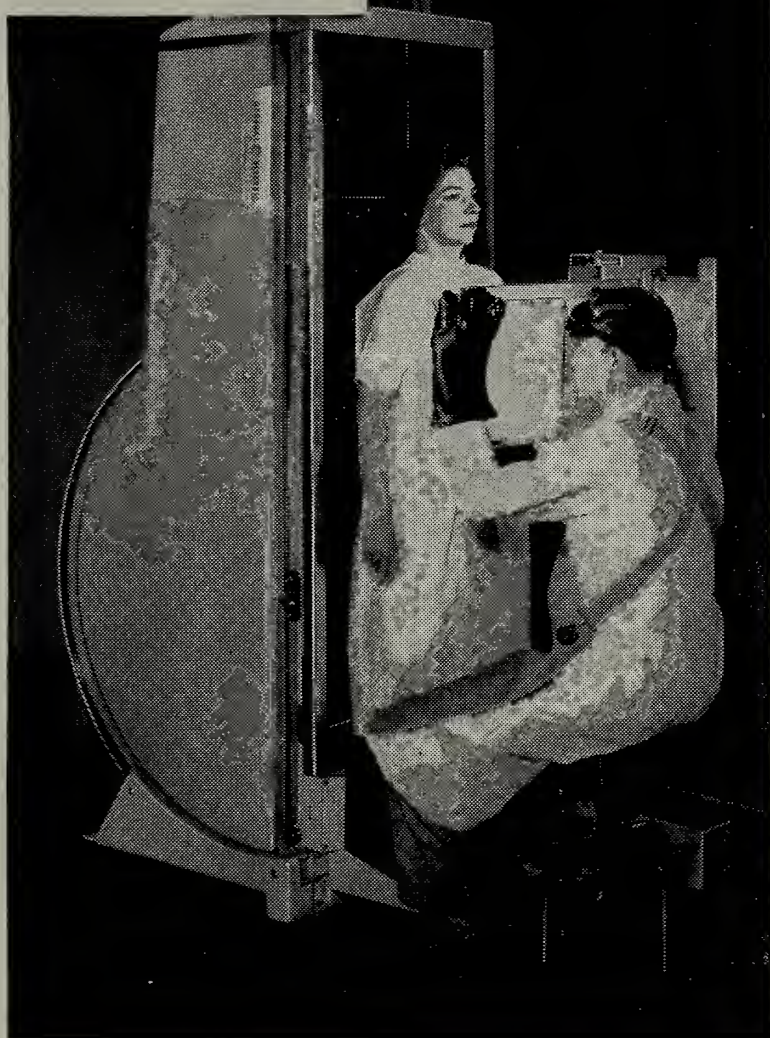
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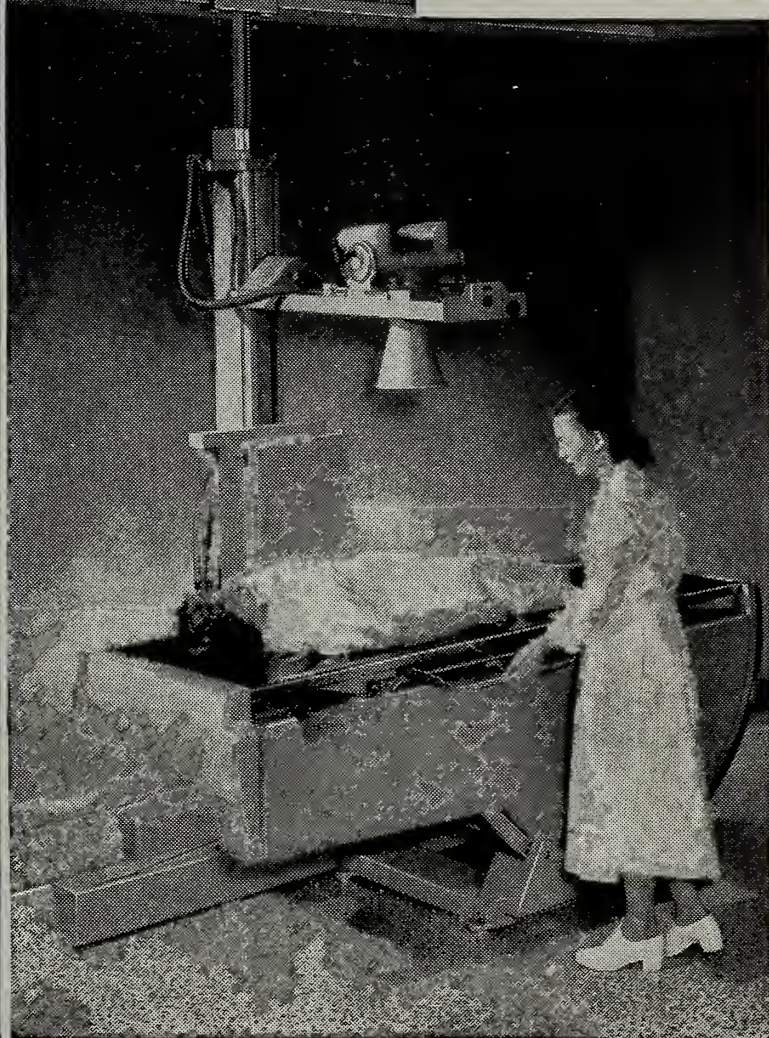
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Licensed Through Endorsement by The State Medical Board

The State Medical Board of Ohio has issued licenses to practice medicine and surgery in the State to the following physicians through endorsement of their certificates to practice in other states (intended residence and medical college of graduation also are given):

January 24—Edward T. Emura, Cincinnati, Washington University; Ralph E. Herendeen, College of Physicians and Surgeons, Los Angeles.

April 3—Arthur J. Abelson, Canton, Western Reserve Univ.; Conrad E. Albrecht, Columbus, Jefferson; Ernest Anderson, Jr., Springfield, Indiana Univ.; Sidney Bolter, Cincinnati, Temple Univ.; John G. Boutselis, Columbus, St. Louis Univ.; James E. Carson, Cleveland, Med. Col. of South Carolina; William H. Christian, Jr., Emory University;

William E. Donze, Berea, St. Louis Univ.; Edward J. Dranginis, Toledo, Marquette Univ.; E. Jay Fieldman, Cincinnati, State Univ. of New York; Roland A. Gandy, Jr., Toledo, Temple Univ.; Hyman L. Gildenhorn, Cleveland, Cornell Univ.; Luis L. Gonzalez, Cincinnati, Univ. of Texas;

Martin R. Haig, Gallipolis, Tufts Medical College; Wren M. Hall, Dayton, Univ. of Louisville; Mark F. Hance, Troy, Univ. of Chicago; William F. Harding, Cleveland, Hahnemann Med. College; Mary C. Harmon, Cleveland, Johns Hopkins Univ.; Walter F. A. Hauser, Univ. of Graz (Austria); Donald W. Hillman, Lima, State Univ. of New York;

Robert J. Kalthoff, Cincinnati, Marquette Univ.; Edward A. Kamens, Canton, Univ. of Vermont; Wladislaw C. Klaczynski, Univ. of Lemberg (Poland); Enzo Krah, Univ. of Florence (Italy); Lee F. Kramer, Defiance, College of Medical Evangelists; Melvin R. Krohn, Cleveland, Univ. of Buffalo;

Charles J. Lapp, Toledo, Wayne Univ.; Isadore Lidsky, Cleveland, Univ. of Toronto; Dorothy Yueh-ching Ma, Peiping Union Med. Col. (China); Dale H. Magleby, Columbus, George Washington Univ.; Kenneth R. McCormack, Columbus, McGill Univ.; Robert J. McDevitt, Columbus, St. Louis Univ.; James P. McMullen, Univ. of Pittsburgh; Hansel T. McSwain, Cincinnati, Univ. of Texas;

Arthur M. Phillips, Columbia Univ.; Chester M. Pierce, Cincinnati, Harvard Medical School; Chester C. Pryor, II, Cincinnati, Howard University; William O. Robertson, Jr., Columbus, Univ. of Rochester;

William M. Savage, Univ. of Louisville; Richard L. Sedlacek, Bellefontaine, State Univ. of Iowa; Norman D. Shapiro, Cleveland, Univ. of Tennessee; Richard D. Smith, Akron, Univ. of Nebraska; Edward K. Steinkopff, Lima, Univ. of Illinois; Cyrus W. Stimson, Cleveland, Univ. of Michigan; James G. Sullivan, Toledo, Georgetown

Univ.; Wildtraut Szolomajer, Euclid, Univ. of Wurzburg (Germany);

Jack E. Tetirick, Columbus, Harvard Medical School; Z. John Vaclavik, Cincinnati, Univ. of Brno (Czech.); William F. Walker, Cincinnati, Duke Univ.; Howard H. Wayne, Cleveland, Bowman-Gray School of Medicine; Herman Wolfson, Akron, Univ. of Chicago; Charles C. Yerbury, Cleveland, New York Medical College.

WHAT TO WRITE FOR

Some booklets, pamphlets and other published material available for the asking or at nominal expense and suitable for the physician's office, library or waiting room, or for his personal information.

* * *

Reviews of Medical Motion Pictures. Booklet No. 7, containing 83 critical reviews of medical and health films which were published in the J. A. M. A. during 1955. Available for 25¢ from the Committee on Medical Motion Pictures, American Medical Association, 535 North Dearborn St., Chicago 10. (Complete set of seven booklets, containing all reviews since 1946 . . . one dollar.)

* * *

Free Health Care for Everyone? Can We Have It? Do We Want It? Would It Really Be Free? A 14-page question and answer leaflet explaining economics of medicine. One of a number published on economic problems by the U. S. Chamber of Commerce. Single copies free on request. You will want it in quantities for your reception room at \$4.50 per hundred, from Economic Research Department, Chamber of Commerce of the USA, 1615 H. Street, N. W., Washington 6, D. C.

* * *

County Medical Society Activities. The results of the 1955 nationwide survey on activities of county societies. Involved 1,225 such organizations, or 64 per cent of the total. Four phases studied: Meetings; activities, including society, public education and community programs; personnel; and financial structure. Available from Council on Medical Service, American Medical Association, 535 North Dearborn St., Chicago 10.

* * *

A Quest Into the Environmental Causes of Cancer of the Lung. A 54 page monograph on the epidemiological, medical, and experimental evidence on environmental substances either known or suspected to be responsible for respiratory cancer in man, written by Dr. W. C. Hueper, head of the Environmental Cancer Section of the National Cancer Institute. Listed as Public Health Monograph No. 36, it is available for 45 cents from Superintendent of Documents, Government Printing Office, Washington 25, D. C.

Activities of County Societies . . .

First District

(COUNCILOR: CHARLES T. ATKINSON, M. D.,
MIDDLETOWN)

ADAMS

The Adams County Medical Society met at the office of the health commissioner in West Union on May 16 for a program after which members had luncheon at the Adams County Hospital. The speaker was Dr. Bert H. McBride, Cincinnati, who spoke on the subject, "Treatment of Head Injuries."

CLERMONT

The Clermont County Medical Society met at the Millcroft Inn on April 18 with Dr. D. K. Ebersold as host. Guest speaker was Dr. Raymond L. Pfister, of Cincinnati, who discussed ear, nose and throat problems.

Dr. George X. Schwemlein, Cincinnati, was guest speaker at the May 16 meeting of the Clermont County Medical Society at the Millcroft Inn. His subject was "Coronary Thrombosis and Complications."

CLINTON

The Clinton County Medical Society cooperated in a meeting of the Clinton County Rural Policy Group March 28 in Wilmington, four physicians participating in the program. Dr. Robert Conard, county health commissioner, described the place of the public health agency in the community and offered suggestions on sanitation and self-help on the part of local residents. Dr. Richard R. Buchanan spoke on procuring physicians in rural areas. Mrs. Buchanan, who also is a physician, spoke on how to use the services of the physician. Dr. Foster J. Boyd, Jr., chief of staff at Clinton Memorial Hospital, described the place of the hospital in the community.

HAMILTON

The April and early May program of the Academy of Medicine of Cincinnati contained the following features:

April 3—Friedlander Lecture; joint meeting with Heart Council; "Some Cardiac Disorders Amenable to Surgical Treatment," Dr. Helen Brooke Taussig, associate professor of pediatrics, Johns Hopkins University School of Medicine, and physician-in-charge of the Cardiac Clinic, Harriet Lane Home, Johns Hopkins Hospital.

April 17—Joint meeting with Nutrition Council—"Effective Medicine for Anemia," Dr. William B. Castle, professor of medicine, Harvard University; director Thorndike Memorial Laboratory, and director of the Second and Fourth Medical Services, Boston City Hospital.

May 1—"Emotional Disturbances of Children," Dr. Reynold A. Jensen, professor of psychiatry and pediatrics, University of Minnesota Medical School, Minneapolis.

In addition to meetings of the Academy, Cincinnati area specialty society meetings were held as follows:

Cincinnati Society of Internal Medicine, April 16.

Cincinnati Urological Society, April 17.

Cincinnati Obstetrical and Gynecological Society, April 18.

Cincinnati Society of Neurology and Psychiatry, April 18.

Southwestern Ohio Society of General Physicians, April 22.

Cincinnati Otolaryngological Society, April 23.

Cincinnati Dermatological Society, May 2.

Radiological Society of Greater Cincinnati, May 7.

Cincinnati Surgical Society, May 9.

The last meeting of the Academy of Medicine of Cincinnati for the 1955-1956 season was held on May 15. The guest speaker was Dr. Martin A. Fischer who discussed the Joint Commission on Accreditation of Hospitals. The dinner meeting was held at the Hotel Alms.

HIGHLAND

Dr. L. Chandler Roettig, associate professor of pulmonary surgery at Ohio State University College of Medicine, spoke at the dinner meeting of the Highland County Medical Society in Greenfield, March 12.

Second District

(COUNCILOR: G. A. WOODHOUSE, M. D.,
PLEASANT HILL)

DARKE

"Heart Disease in Infancy and Childhood," was discussed by Dr. Don Hosier, of Columbus, at the April 17 meeting of the Darke County Medical Society. The dinner meeting was held in the James Hotel in Greenville.

"Problems Associated with the Cost of Hospital Care Insurance," was the subject discussed at the May 15 meeting of the Darke County Medical Society in Greenville. The speaker was Mr. Kammer, associate director of hospital care.—Maurice Kane, M. D., Secretary-Treasurer.

MIAMI

The annual dinner meeting of the Miami County Medical Society with the Woman's Auxiliary was held in the Piqua Country Club. Dr. Leonard Loushin, on the psychiatric staff of Cleveland Clinic, gave an educational talk with the provocative title, "How To Recognize a Nervous Person."

MONTGOMERY

The General Practice Section of the Montgomery County Medical Society met on April 18 at Suttmiller's Restaurant for luncheon and a

program. The subject, "Differential Diagnosis of Jaundice," was discussed by Dr. S. Paul Rose.

The Internal Medicine Section of the Montgomery County Medical Society met on April 25 in the Van Cleve Hotel for a social hour, dinner and meeting. The speaker for the occasion was Dr. George J. Hamwi, Ohio State University and newly elected Treasurer of the Ohio State Medical Association, whose subject was "Recent Advances in Endocrinology."

A combined meeting of the General Practice Section of the Society and the Montgomery County Chapter of the Ohio Academy of General Practice was held on May 16 at Suttmiller's Restaurant with luncheon. The subject of discussion was "Anesthesia and Analgesia in Labor and Delivery," with Dr. James C. Burt as the speaker.

Third District

(COUNCILOR: JAMES R. JARVIS, M. D., VAN WERT)

ALLEN

Members of the Lima and Allen County Academy of Medicine viewed a closed circuit television program at their dinner meeting on April 17 at the Shawnee Country Club. The showing of "Acute Abdominal Problems" was presented by the Upjohn Company.

LOGAN

Members of the Logan County Medical Society with their ladies enjoyed the annual dinner party

on April 6 at the Old Logan House, Bellefontaine. The speaker was Mack Sauer, Leesburg editor and humorist.

SENECA

Dr. James R. Jarvis, Van Wert, Councilor of the Third District, was guest speaker at the April 17 dinner meeting of the Seneca County Medical Society and Auxiliary in the Fostoria Country Club. Dr. Jarvis discussed organizational matters.

Fourth District

(COUNCILOR: PAUL F. ORR, M. D., PERRYSBURG)

LUCAS

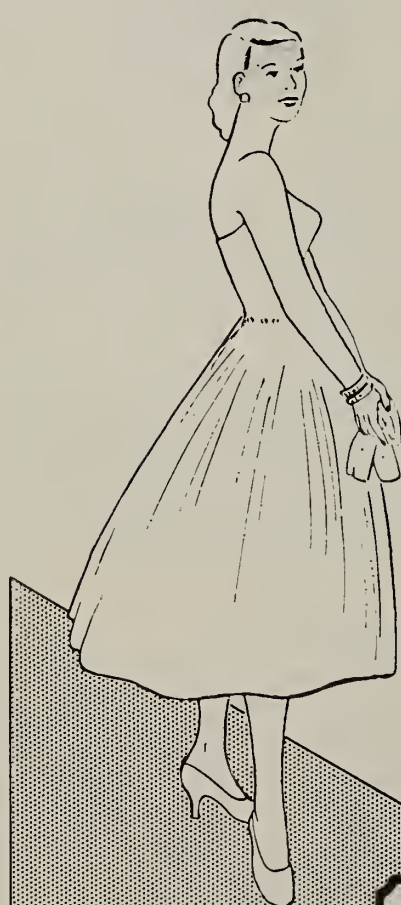
The April program of the Academy of Medicine of Toledo and Lucas County included the following features:

April 6—General Meeting at which the Intern-Resident Program was featured by the presentation of papers by hospital staff members.

April 20—Medical Section meeting.

April 27—General Practice Section—A panel discussion on the topic, "Moles, Warts and Other Skin Tumors," with the following panelists participating: Dr. E. F. Glow, moderator; Drs. F. C. Curtzwiler, William Eyster and Richard Hotz.

A team of Army surgeons from the office of the Surgeon General of the Army in Washington presented the program for the Inter-Hospital Postgraduate Lecture Series on May 10 in the



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1. Grayzel, H. G., Heimer, C. B., and Grayzel, R. W.: New York St. J. Med. 53:2233, 1953. 2. Heimer, C. B., Grayzel, H. G., and Kramer, B.: Archives of Pediatrics 68:382, 1951. 3. Behrman, H. T., Combes, F. C., Bobroff, A., and Leviticus, R.: Ind. Med. & Surgery 18:512, 1949. 4. Sobel, A. E.: Scientific Exhibit, A.M.A. Meet. 1955. 5. Marks, M. M.: Missouri Med. 52:187, 1955.



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1 lb. jars.

headquarters of the Academy of Medicine. This was the 30th in the series of lectures and was sponsored by the Medical Advancement Trust of the Maumee Valley Hospital and the Trauma Committee of the Toledo Chapter, American College of Surgeons.

The program was in the form of a panel discussion on the topic, "Medical Management of Disaster." The following persons presented the subject from the various phases indicated: Colonel Joseph R. Shaeffer, "Management of Mechanical and Thermal Injuries in Disaster"; Colonel Albert J. Glass, "The Management of Psychological Problems Occurring in Disaster"; Colonel Joseph D. Goldstein, "Weapon Effects as Casualty Producing Agents—Immediate and Delayed"; Lt. Col. J. D. Goldstein, "Organization and Survival Care"; Lt. Col. Arthur Steer, "Estimation of Casualties and Types of Casualties."

SANDUSKY

Dr. Theron Hopple, of Toledo, was guest speaker at the May 16 meeting of the Sandusky County Medical Society at Memorial Hospital in Fremont. Subject of discussion was "Emergency Treatment of Head Injuries."

Fifth District

(COUNCILOR: GEORGE W. PETZNICK, M. D.,
CLEVELAND)

CUYAHOGA

An afternoon and evening meeting of the Academy of Medicine of Cleveland with intervening dinner was held on April 20.

Guest speaker for the occasion was Dr. James C. White, professor of surgery, Harvard Medical School and chief of the neurosurgical service of the Massachusetts General Hospital. His subject was "Newer Concepts and Treatment of Visceral Pain."

Others participating in the program and the subjects discussed were the following:

"Drugs Useful in Evaluation and Management of Pain Complaints," Dr. Morris W. Stroud.

"The Use of Continuous Segmental Anesthesia in Chronic Pain Problems," Dr. Robert A. Hingson.

"Methods for Study of Afferent Pathways in the Laboratory Animal," Dr. William F. Collins.

"Present Usefulness and Limitations of Pain Surgery," Dr. Frank E. Nulsen.

The Section on Surgery of Trauma met on April 27. The subject discussed at this meeting was "Treatment of the Severely Traumatized Patient." The following Physicians participated: Drs. D. M. Glover, David Chambers, Charles Hubay, Harvey Mendelsohn, George Phalen and John Davis.

The Experimental Medicine Section of the Academy and the Cleveland Section of the Society for Experimental Biology and Medicine met on April 23.

Sixth District

(COUNCILOR: CARL A. GUSTAFSON, M. D.,
YOUNGSTOWN)

COLUMBIANA

Plastic surgery was the topic of discussion at the April 17 meeting of the Columbiana County Medical Society in the Hotel Wick, Lisbon. The speaker was Dr. John A. Gaisford, of the University of Pittsburgh. Dr. J. Keith Rugh, of East Liverpool, president, presided at the meeting.

The scientific session followed a joint dinner meeting with the Woman's Auxiliary. For the ladies' program, Dr. A. P. Falkenstein showed a film describing the place in medicine of the medical technologist.

MAHONING

A Medical Legal Symposium was conducted before members of the Mahoning County Medical Society on April 17 with members of the Mahoning County Bar Association as guests. The symposium was in the form of a discussion of two hypothetical trauma cases.

Chairman of the symposium was Dr. Sidney Franklin who is a physician and attorney.

Medical experts who participated were: Dr. Wallace Duncan, Cleveland; Dr. Earle B. Kay, Cleveland; Dr. Paul L. Weygandt, Akron, and Dr. Henry L. Zimmerman, Cleveland.

Attorneys who took the parts of legal interrogators were: Clarence E. Kroeger, Akron; R. Crawford Morris, Cleveland; David Sindell, Cleveland, and Craig Spangenberg, Cleveland.

PORTAGE

The regular meeting of the Portage County Medical Society was held at the Portage County Memorial Hospital at Ravenna on March 27. The program consisted of a discussion of the development and present status of intracardiac pressure readings and cardiac surgery. Slides were shown illustrating the talks. The speakers were Dr. Harry Zimmerman, director of the Cardiovascular Laboratory, St. Vincent Charity Hospital, Cleveland, and Dr. Earle Kay, thoracic and cardiovascular surgeon of Cleveland. Refreshments were served following the meeting.—Arthur L. Knight, M. D., Secretary-Treasurer.

STARK

The scheduled feature event for May was the annual picnic on the 23rd at Congress Lake Country Club. The Woman's Auxiliary arranged for an informal card party in the afternoon, dinner and special entertainment in the evening.

SUMMIT

Guest speaker for the May 1 meeting of the Summit County Medical Society in the Akron General Hospital Auditorium, was Dr. Edwin W. Gerrish, assistant professor of pediatric surgery, Western Reserve University and director of pediatric surgery at University Hospitals. His

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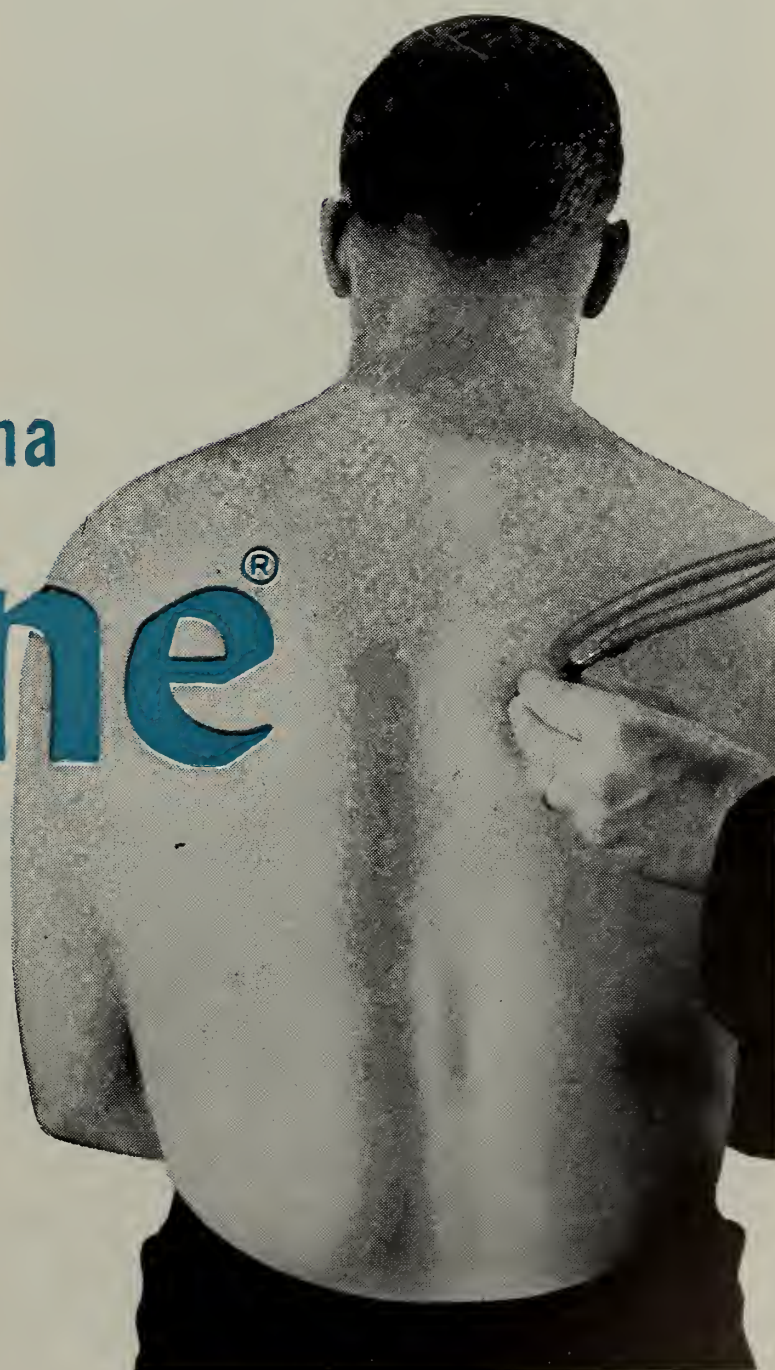
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1. Johnston, T. G., and Cazort, A. G.: J. Allergy 27:90, 1956. 2. Schwartz, E.: New York J. Med. 56:570, 1956. 3. Schiller, I. W., et al.: J. Allergy 27:96, 1956.

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subject was "Pediatric Abdominal Surgery." The meeting was held following dinner at the Akron City Club.

The Summit County Medical Society joined with the Summit County Unit of the American Cancer Society in sponsoring a panel discussion over Akron Station WAKR-TV on April 23, on the subject, "Cancer and What Is Being Done About It."

Taking part in the panel were the following physicians: Dr. George R. Dochat, Dr. Thomas S. Brownell, Dr. Charles J. Miller, and Dr. Henry Kraus. Moderator was Dr. Ray H. Sandefur, chief of the speech department at the University of Akron. Also taking part was Mrs. C. W. MacCready, director of the volunteer services for the local Cancer Society.

Seventh District

(COUNCILOR: ROBERT HOPKINS, M. D., COSHOCTON)

BELMONT

The Belmont County Medical Society met with the Auxiliary on May 17 at the Belmont Hills Country Club for dinner and a program.

TUSCARAWAS

The April 19 meeting of the Tuscarawas County Medical Society was held at Union Hospital. Dr. M. E. Lahey, of the Children's Hospital staff in Cincinnati, spoke on blood and its problems and laboratory procedure in children's care.

Eighth District

(COUNCILOR: WILLIAM D. MONGER, M. D., LANCASTER)

WASHINGTON

The Washington County Medical Society was host to the Parkersburg Academy of Medicine at a dinner meeting of the Mid Ohio Valley Academy of Medicine held on April 18 in Hotel Lafayette, Marietta.

The program featured a symposium on the neurologic and psychiatric aspects of the headache. The speakers were Dr. Warren L. Leimbach, member of the neurosurgical staff at Ohio State University, and Dr. Charles H. Harding, on the psychiatric staff of Harding Sanitarium, Worthington.

Special guest was Dr. Robert S. Martin, Zanesville, President-Elect of the Ohio State Medical Association.

Ninth District

(COUNCILOR: C. L. PITCHER, M. D., PORTSMOUTH)

LAWRENCE

The following paragraphs are excerpts from the *Ironton Tribune* report:

The Lawrence County Medical Society, continuing its study of community health problems and services, gave unanimous approval to establishment of a cardiac clinic in Ironton. The action was approved at a meeting of the group on April 4.

The clinic, to be affiliated with the Ohio Department of Public Welfare and crippled children

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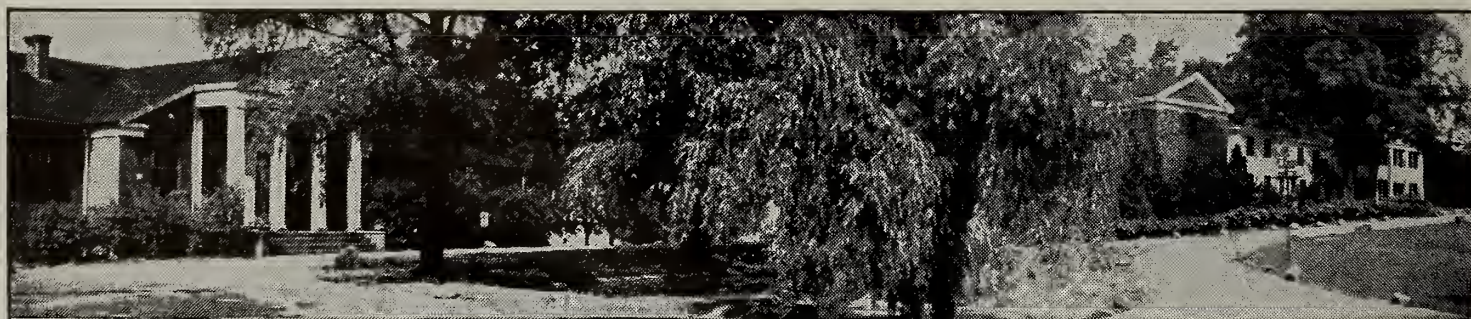
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services, would bring specialists to the county on a regular basis.

Participating in discussion of the new program were Dr. O. W. Hosterman, director of the cardiac clinic at Children's Hospital in Columbus; Dr. D. M. Hosier and Dr. Howard Sirak, also from Columbus.

The Lawrence County welfare clinics, held regularly at the General Hospital, are the first of their kind, federally supported in the U. S. However, it was agreed that additional facilities would be needed to assure successful operation.

In order to facilitate processing of welfare cases at the clinic, a medical report will be given each patient for reference to a family physician. Director Walden Fannin was publicly commended by resolution for his work in organizing the welfare department.

Further work on welfare services will be contingent with a meeting on rehabilitation (scheduled later in the week).

In other business at Tuesday's meeting, the Society unanimously agreed to appropriate \$500 from the treasury for establishment of a hospital library.

SCIOTO

On April 9 the Scioto County Medical Society met in the General Hospital Nurses' Auditorium in Portsmouth. A film, "The Cardiac Patient in Stress" moderated by Dr. Prodger of Tufts Medical School, was shown with discussion by Drs. Levine and White. The program was arranged by Dr. R. L. Wagner.

The Scioto County Medical Society met on May 8 at Harold's for dinner and a meeting. Dr. Francis A. Scott, Huntington, W. Va., spoke on the subject, "Cervicobrachial Syndrome."

Tenth District

(COUNCILOR: E. H. ARTMAN, M. D., CHILLICOTHE)

FRANKLIN

Following are excerpts from a report in the *Ohio State Journal*, Columbus morning newspaper:

... The Emergency Committee of the Columbus Academy of Medicine staged a highly successful surprise disaster test at the Fairgrounds Coliseum (April 30).

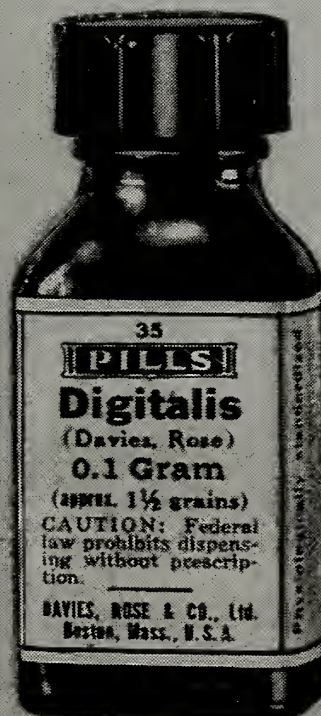
The Academy counted on 200 volunteers to show up without a single advance warning of the 6:30 p. m. emergency call. But more than 250 appeared—doctors, dentists, nurses, medical technicians, office workers and others who have pledged themselves to medical work in disaster.

"It was a fine demonstration—a success," said Dr. David K. Heydinger, chairman of the Academy's committee. "When you consider that there was no advance warning to the men and women who are our lay medical workers, the mock attack and demonstration was perfect."

Civil Defense and Red Cross officials and their crews were also on duty. In general supervision with Dr. Heydinger were his co-chairman, Dr.

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Ollie M. Goodloe, Columbus health commissioner . . . and . . . Dr. Drew L. Davies, acting disaster chairman of the Red Cross, and co-chairman of the OSMA Committee on National Defense.

The May program meeting of the Columbus Academy of Medicine was held on the 21st at the Columbus Art Gallery. The guest speaker was Dr. William S. McCann, the Dewey professor of medicine and physician-in-chief of the University of Rochester, Rochester, N. Y., who spoke on the subject, "Pulmonary Ventilation and Cardiac Blood Flow."

ROSS

Awards were presented recently to winners in the essay contest sponsored among high school students by the Ross County Academy of Medicine and Woman's Auxiliary. Cash prizes of \$50, \$30 and \$20 were given to three high school students by Dr. Charles E. Hoyt, president of the Academy and Mrs. Robert Giesler, president of the Auxiliary. The subject was "The Advantages of Private Medical Practice." The three winning essays were entered in the national contest sponsored by the Association of American Physicians and Surgeons Freedom Program, Inc.

Eleventh District

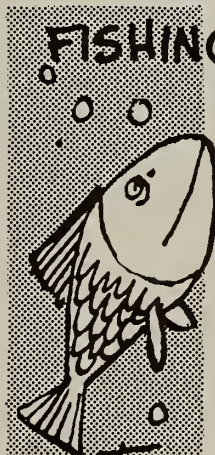
(COUNCILOR: H. T. PEASE, M. D., WADSWORTH)

RICHLAND

The regular meeting of the Richland County Medical Society was held at the Westbrook Country Club, April 19. The meeting was a combined dinner meeting with the Richland County Bar Association.

A business meeting was held following the dinner, with Dr. P. O. Staker presiding.

Following the business session, Attorney Robert L. Ross, president of the Richland County Bar Association, introduced the speaker of the evening, Attorney Harold J. McNeal, Supreme Court practitioner, Cleveland, who spoke on "Malpractice."—C. F. Curtis, M. D., Secretary.



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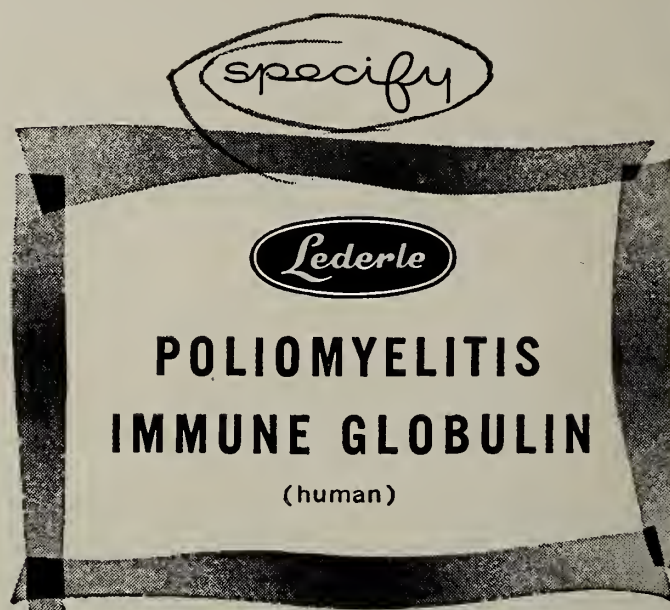
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Past-President and Finance Chairman—Mrs. Karl Ritter,
1420 Shawnee Rd., Lima

Chairman Publicity Committee—Mrs. Carl F. Goll

AUGLAIZE

Members of the Auglaize County Medical Auxiliary met for their March meet at the home of Mrs. D. L. Kile. During their short business meeting, it was announced that March 30 was the date for nation-wide observance of Doctor's Day.

Mrs. John Brock pleased the members and guests with an interesting display of Foreign Imports, lovely gift items, whose background she described.

CLARK

Mrs. Carl Reuter entertained members of the Woman's Auxiliary to the Clark County Medical Society in her home on March 22. A book review by Mrs. Charles Zimmerman was presented during the afternoon. A dessert course was served by Mrs. Reuter and her co-hostess, Mrs. E. Paul Greenawalt.

COSHOCTON

Mrs. Gerald Foster, Coshocton, was hostess to the Woman's Auxiliary to the Coshocton County Medical Society on February 14. It was announced that the members of the Auxiliary had cooperated 100 per cent with the *Today's Health* program by purchasing subscriptions for the husbands' reception rooms. Mrs. Robert Johnson was appointed chairman for nurse recruitment, which will include plans for the April tea for high school girls interested in nursing. Colored slides of his Caribbean cruise were presented by Mr. Dan Meek.

Mrs. G. M. Ebersole, Newcomerstown, was hostess to the Coshocton County Auxiliary on March 13. April 18 was chosen as the day for the tea for high school girls of the county interested in nursing. All four grades of high school will be included in this program. The following officers were elected: Mrs. W. E. Pfaadt, president; Mrs. R. R. Johnson, president-elect; Mrs. N. L. Wright, secretary; Mrs. J. C. Briner, treasurer. A book review on Sloan Wilson's "The Man in the Gray Flannel Suit" was given by a guest, Mrs. William Sander. Mrs. Everhard, district director, was an additional guest.

CUYAHOGA

The Woman's Auxiliary to the Cleveland Academy of Medicine paid its annual salute on

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*Fishberg, A. M.: Hypertension
and Nephritis, ed. 5, Philadelphia,
Lea & Febiger, 1954, pp. 177-178.

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GYNECOLOGY & OBSTETRICS—Obstetrics & Gynecology, three weeks, Oct. 22. Office & Operative Gynecology, two weeks, Sept. 17. Vaginal Approach to Pelvic Surgery, one week, Sept. 10.

MEDICINE—Electrocardiography & Heart Disease, two-week basic course, July 9. Internal Medicine, two weeks, Sept. 24. Gastroscopy & Gastroenterology, two weeks, Sept. 10. Gastroenterology, two weeks, Oct. 22. Dermatology, two weeks, Oct. 15.

RADIOLOGY—Diagnostic X-Ray, two weeks, Sept. 17. Clinical Uses of Radioisotopes, two weeks, Oct. 8.

UROLOGY—Two-week course Oct. 8. Cystoscopy, ten days, by appointment.

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February 29 in Higbee Auditorium to the student nurses in the city's 11 schools of nursing and selected an outstanding junior from each to receive an award. It also went on record opposing the enactment of H. R. 7225, a measure now pending in the Senate which would add a cash disability benefit system to social security. The resolution calling for the stand was introduced by Mrs. Frank S. Weinman, legislative chairman. Copies of the resolution are to be sent to Senators, John W. Bricker and George H. Bender.

Mrs. Charles A. Obert, nurses' award chairman, presented the awards to the eleven winners.

Mary Meade, oldest registered nurse in the city in point of service, who is from Huron Road Hospital, was a guest of honor and in her original uniform.

Realization that nurses' work must be patient-centered and not task-centered and that patients are people who come in assorted sizes, races and temperaments was the basic tenet advanced by Helen Harding, "Miss Student Nurse of Ohio for 1955" in her prize-winning essay which she read to the luncheon guests.

Mrs. Christopher Colombi presided at the session, Mrs. James N. Wychgel, chairman of the "Stay at Home Night" the Auxiliary sponsored last month, reported that the proceeds for the American Medical Education Foundation to help finance medical education were about \$1,300.

Guests who spoke briefly included Dr. Charles L. Hudson, then President of the Ohio State Medical Association; Dr. Howard Taylor, Vice-President of Cleveland Academy of Medicine; and Dr. George Petznick, Councilor for the Fifth District of Ohio State Medical Association.

ERIE

Dr. Eldon Smith, who has been director of Bowling Green University's summer theater at Huron for the past seven summers, addressed members of the Woman's Auxiliary to the Erie County Medical Association and their guests in a recent meeting. The luncheon crowd audience in the Business Woman's Club included many theater goers whom Dr. Smith had met at performances in Huron.

Mrs. Watson Parker was appointed chairman of the nominating committee, which also includes Mrs. H. L. Sowash, Mrs. F. O. Fry, Mrs. Paul Squire and Mrs. Arthur Groscost. Mrs. Groscost requested donations of playing cards (both pinochle and regular decks) to augment the stock of books and magazines for the Auxiliary book carts at Providence and Good Samaritan Hospitals.

FAIRFIELD

"Meeting Tomorrow's Problems Today" drew 76 interested persons to Lancaster Country Club. The occasion was the annual Guest Night dinner meeting of the Woman's Auxiliary to the Fairfield

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*McLester, J. S., and Darby, W. J.: *Nutrition and Diet in Health and Disease*, ed. 6, Phila., Saunders, 1952, p. 195.

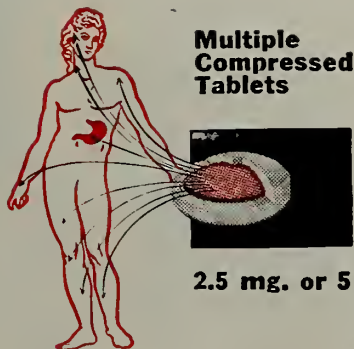
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References: 1. Boland, E. W., *J.A.M.A.* 160:613, February 25, 1956. 2. Margolis, H. M., *et al.* *J.A.M.A.* 158:454, June 11, 1955. 3. Bollet, A. J., *et al.* *J.A.M.A.* 158:459, June 11, 1955.

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ALL THE BENEFITS OF THE "PREDNI-STEROIDS" PLUS POSITIVE ANTACID ACTION TO MINIMIZE GASTRIC DISTRESS

County Medical Society, held in the month of March.

Guest speakers were Jay Bennett, assistant director of Juvenile Research, Columbus; Robert Payne, assistant superintendent of Lancaster Schools; Rex Percelle, assistant superintendent of Fairfield County schools; and the Rev. Charles Harrison, Chaplain at Boys' Industrial School.

The subject of the symposium, "Meeting Tomorrow's Problems Today" dealt with problem children and their treatment.

Juanita Rankin Fultz delighted the group with piano selections preceding dinner. In charge of the program was the chairman, Mrs. C. H. Hamilton, who introduced the guest speakers; Mrs. George F. Jones and Mrs. Clifford Snider.

The president, Mrs. H. M. Amstutz welcomed the group assembled. At the close of the symposium she announced the coming annual tea for Prospective Nurses would be held with Mrs. Charles Clark as chairman.

The Auxiliary members gave a party for the residents of the County Home on February 28. A potted hyacinth and a box of homemade cookies were presented to each resident. The nurses' choral group under the direction of Mrs. Willis Fausch entertained with a number of favorite hymns. The committee in charge of the annual party was composed of Mrs. William Jasper, Mrs. Galon Rodabaugh, Mrs. Chester Swett and Mrs. F. A. Dowdy.

FRANKLIN

Piano music "From Bach to Boogie-Woogie" was offered by Mrs. Elwood Guernsey when the Woman's Auxiliary to the Columbus Academy of Medicine met March 19 in the Jai Lai Restaurant for dinner.

Mrs. A. L. Kefauver, president, announced the following newly elected officers to serve the Auxiliary during 1956-57: Mrs. George I. Nelson, president; Mrs. Ollie M. Goodloe, president-elect; Mrs. Richard W. Zollinger, vice-president; Mrs. Harold I. Humphrey, recording secretary; Mrs. Charles W. Pavey, corresponding secretary; and Mrs. James J. Conn, treasurer.

The meeting was arranged by Mrs. Ben Arnoff, Worthington, social chairman, and Mrs. Perry Ayres. Working on reservations were Mrs. Edwin R. Zartman, and Mrs. Robert L. Friedman.

Mrs. Nelson, who holds a Ph.D. degree in psychology, is president of the Children's Mental Health Center Board of Trustees and chairman of the Advisory Council to the Juvenile Division of the Ohio State Department of Mental Hygiene and Correction.

GREENE

"Anything can happen" was the comment of Mr. Richard Anderson of Battelle Memorial Institute of Columbus in speaking on "Satellite Saucers and Related Objects" at a dinner of the Auxiliary to the Greene County Medical Society



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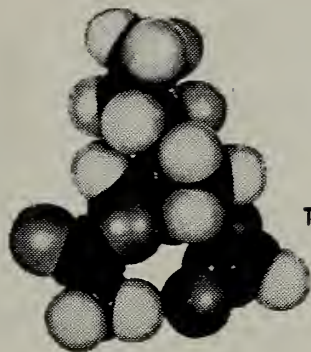
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at Christ Episcopal Parish House, E. Church St., on March 7.

Mrs. R. David Warner, president-elect, presided in the absence of the president, Mrs. R. D. Hendrickson who is on vacation in Mexico. Husbands of members were guests and Dr. Charlotte Ames, president of the medical society, also was a guest.

There were covers for 49 at the dinner. Arrangements were in charge of Mrs. H. C. Schick, Mrs. Reid P. Joyce and Mrs. Harold R. Tharp of Xenia and Mrs. Donald F. Kyle of Cedarville.

HARDIN

Eighteen members of the Auxiliary to the Hardin County Medical Society enjoyed dinner at their March meeting in the dining room at Hardin Memorial Hospital. Mrs. Robert Schultz, president, conducted the business session.

Mrs. R. G. Schutte, chairman, gave the report of the nominating committee and Mrs. Robert Thomas and Mrs. Don Dewar were named to serve as the auditing committee. Miss Mabel Selin, administrator at Hardin Memorial, gave a talk describing the work at the hospital and stressed the need for additional rooms and beds to accommodate the overflow of patients. She also conducted a tour of the hospital, pointing out new equipment recently purchased.

HURON

The home of Dr. and Mrs. George Linn of Norwalk was the meeting place of the Woman's Auxiliary to the Huron County Medical Auxiliary on March 9. A dessert luncheon was served by Mrs. Linn, assisted by Mrs. Charles Edel.

Miss Pat Larson, speech therapist in the Norwalk and Willard schools, was the guest speaker. She spoke of the problems of functional and organic speech defects in children and paid tribute to Jane Beasely, a Norwalkian, who pioneered in this field.

Mrs. T. H. Smith was cited for honor in putting Huron County over the top in *Today's Health* magazine contest. Her score is 1,300 per cent, approximately twice the score of the runner-up and places Huron County in first place in the United States to date.

KNOX

Hobbies was the theme of the second meeting of the Golden Age Club on March 16 in the basement of the Memorial Building. Ninety members were present.

The meetings of the Golden Age Club are sponsored and planned by the Auxiliary to the Knox County Medical Association.

At the meeting held March 28, in the Mt. Vernon State Hospital, Mrs. James McLarnan was named president for the coming year.

Other officers are: Mrs. O. W. Rapp, president-elect; Mrs. George Imhoff, vice-president; and Mrs. C. E. Cassaday, secretary-treasurer. On

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*Moyer, J. H., and Hughes, W. M.:
J. Chron. Dis. 2:678, 1955.

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the nominating committee were Mrs. Richard Gomer, Mrs. Carroll Conard and Mrs. Cooper Russell.

A report of the Mercy Hospital guild was given by Mrs. Julius Shamansky. Mental health pamphlets have been distributed by Mrs. Robert Eastman to ministers in the city from which sermons will be prepared.

Donations of \$5 were made to the Heart Fund; \$10 to the Knox County Society for Crippled Children and \$50 to the American Medical Education Foundation.

At the program after the business meeting topics from *Today's Health* magazine were discussed, and Mrs. C. E. Cassaday discussed an article in plastic eyeglasses. Mrs. Robert Eastman led a discussion on "Are You Afraid of Growing Old?"

LICKING

The February dinner meeting of the Woman's Auxiliary to the Licking County Medical Society was held in The Carousel. Mrs. Harry Shields, social service worker with the Newark Hospital, was the speaker. She gave details of the many problems met and solved daily by her department.

On March 7 several representatives of the Auxiliary attended the initial meeting of the volunteer service program for Newark Hospital held in the Ohio Power Building.

The high school girls who filed applications for nursing scholarships were guests of the Auxiliary at a "Coke Party" held in the home of Mrs. Ralph Pickett, on March 14. They were entertained by Miss Nancy Boyer, a student at Denison University, who did several monologues.

LORAIN

Mrs. George H. Hoke of Lorain was elected president of the Woman's Auxiliary to Lorain County Medical Society at a luncheon at Spring Valley Country Club, which was the March meeting. Dr. Viola Startzman, pediatrician of the Cleveland Clinic, was guest speaker. Dr. Startzman spoke on the topic, "Advances in Pediatrics in the Last 10 Years."

President-elect is Mrs. Gordon Smith of Elyria; vice-president, Mrs. Robert Thomas, Elyria; recording secretary, Mrs. Herbert Rosenbaum, Lorain; corresponding secretary, Mrs. William Kishman, Lorain; and treasurer, Mrs. Paul Kopsch, Lorain.

Mrs. Franz Gruen presided at the business session when a motion was passed to buy occupational therapy material for patients in Pleasant View Sanatorium. Work in ceramics, weaving and leathercraft will be aided by this contribution.

MAHONING

Over 100 women, wives of local attorneys and medical men, attended the brunch given on March 20 in the Cascades Room at Hotel Pick-Ohio as a combined meeting of the Woman's

Auxiliaries to the Mahoning County Bar Association and the Mahoning County Medical Society.

Paul H. Luce, principal of Chaney High School, was the speaker. His topic was "Mental Health." In connection with Mr. Luce's talk a cartoon-type moving picture was shown. Mrs. Morris Rosenblum was chairman for the day and introduced the speaker. Mrs. John Noll gave a memorial to the late Dr. William M. Skipp.

MIAMI

Luncheon preceded the program at the March meeting of the Miami County Medical Society Woman's Auxiliary at Piqua Memorial hospital nurses' home. The attractively appointed and delicious buffet luncheon was supervised by Mrs. Richard Chronerberry, hospital dietitian.

Guest speaker was the Rev. John C. Inglis, whose inspirational talk reviewed experiences during his life as the son and brother of physicians as well as the father of a medical student, soon to become a doctor.

During the business session, names of some of the applicants for the Auxiliary's 1956 scholarship for student nurses were considered. Tickets were distributed for the Auxiliary's annual dance to be held April 7 at the Troy Country Club for the benefit of the nurse recruitment fund.

RICHLAND

Paul Bush, president of the Mansfield City Council, city traffic safety representative and former mayor, spoke on the subject. "Traffic Safety or The Misguided Missile," when members of the Woman's Auxiliary to the Richland County Medical Society met on March 5 at the Woman's Club. He was introduced by Mrs. Paul Lee, program chairman.

Mrs. Robert Peirce, president, conducted the business session. Reports were given by Mrs. Harlan Knierim, Mrs. Wendell Bell, Mrs. Robert Tawse and Mrs. Robert Crawford.

The following new members-at-large were announced: Mrs. H. W. Smith, Ashland; Mrs. G. B. Fuller, Loudonville, and Mrs. M. D. Shilling, Ashland. Guests were Mrs. James Secrist, Mrs. Robert Jones, Mrs. J. D. Waldron, Mrs. Paul Bush and Mrs. Charles Shafer. Mrs. Alvin Bales was a new member present.

Hostesses for the luncheon which preceded the program were Mrs. Sam Lerro, Mrs. Roy Curry, Mrs. Albert Selfman, Mrs. Charles Curtiss and Mrs. Charles Keller.

SUMMIT

Forty-nine public and private health, welfare and education agencies had display booths at the annual Health Days Exhibit, sponsored by the Woman's Auxiliary to the Summit County Medical Society on March 3, 4, and 5 in the M. O'Neil Co. auditorium.

SCIOTO

A luncheon and style show was featured at the Woman's Auxiliary of Scioto County Medical

Society at their March meeting at the Elks City Club auditorium.

"Our nurse recruitment program has become one of our major projects," explained Mrs. B. U. Howland, president of the doctors' wives' group. "We feel it is of vital importance to do everything possible to interest high school students in the profession of nursing. This last year we have been giving financial assistance to a student nurse.

"To continue our activities along those lines is the reason for this event, and we are deeply grateful to Tilene's for making the style show possible."

Mrs. Otto F. Apel, Jr., chairman of the ways and means committee of the doctors' wives' auxiliary, announced that part of the funds raised by the luncheon style show will be used on the purchase of a new film on nursing, which will be shown before each high school group in the county under the supervision of Mrs. Clyde M. Fitch.

Mrs. William C. Hugenberg was chairman of the style show committee with Mrs. Milton Levine in charge of tickets and reservations. Others who served on the committee included Mrs. Apel, Mrs. Donald Appleton, Mrs. Sol Asch and Mrs. Gohmann.

TUSCARAWAS

With approximately one hundred present, members of the Tuscarawas County Medical Society entertained members of their office staffs at a dinner sponsored on March 22 at Union Country Club by the Auxiliary to the Medical Society. This social gathering has been established as an annual event.

The featured entertainer for the evening was George Tonak, pianist-comedian of New York City, who travels and performs under the sponsorship of the makers of Diaparene.

Also on the program were variety acts under the sponsorship of The New Philadelphia Little Theatre with William B. Steis as master of ceremonies.

Mrs. Philip Doughten was chairman of the committee which included Mrs. D. M. Ceramella and Mrs. Judson Reamy, all of New Philadelphia; Mrs. George D. Woodward of Dover and Mrs. C. J. Nicosia of Bowerston.

WASHINGTON

Members of the Washington County Medical Society and the Auxiliary to the Society had a dinner meeting on March 14 in the Rufus Putnam Room at Hotel Lafayette. Dr. and Mrs. William Stewart were in charge of arrangements. During dinner recordings of organ selections by Mrs. William J. Garrison were played.

For the program Paul and Roger Garrison presented highlights of high fidelity recordings illustrating vocal and instrumental renditions and sound effects.

INDEX TO ADVERTISERS

Ames Company, Inc.	552
Ann Arbor School	656
Appalachian Hall	570
Atlas Pharmaceutical Laboratories	578
Ayerst Laboratories, Inc.	658
Baker Laboratories, Inc.	563
Breon, George A., & Company	681
Burroughs Wellcome & Co. (U. S. A.) Inc.	574
Ciba Pharmaceutical Products, Inc.	579
Coca-Cola Company	576
Cook County Graduate School of Medicine	669
Corn Products Sales Co. (Karo)	566
Davies, Rose & Co., Ltd.	667
Desitin Chemical Company	663
Flint, Eaton & Company	679
Foot-so-Port Shoe Co.	674
General Electric Company, X-Ray Dept.	659
Harding Sanitarium	573
Hoffmann-LaRoche, Inc.	Insert Between Pages 636 - 637
Lakeside Laboratories, Inc.	557, 669, 674
Lederle Laboratories	612-613; 668
Lilly, Eli, and Company	580
Loma Linda Food Company	575
Luzier's, Inc.	576
Magnetic Springs Foundation	571
Mallard, Inc.	672
Manitowaning Lodge	668
McMillen Sanitarium	573
Medical Protective Company	656
New York Polyclinic Medical School	570
Parke, Davis & Company	684 and Inside Back Cover
Pfizer, Chas. & Co., Inc.	567, 665
Riker Laboratories, Inc.	561
Rocky Glen Sanatorium	576
Sanborn Company	683
Sawyer Sanatorium	572
Schering Corporation	564-565, 653 and Insert Between Pages 572 - 573
Scroggins, Clayton L., Associates (Medical-Dental Management)	579
Searle, G. D. & Company	651
Sharp & Dohme, Inc.	671
Smith, Kline & French Laboratories	559, and Back Cover
Squibb, E. R. & Sons, Division of Olin- Mathieson Chemical Corporation	657, 678
Stoneman Press	578
Tutag, S. J. & Company	662
Upjohn Company	571
U. S. Vitamin Corporation	680
Vitamin Food Co., Inc.	670
Wallace Laboratories	673
Wendt-Bristol Company	668
Wickhaven Sanitarium	666
Windsor Hospital, Inc.	666
Winthrop Laboratories	682
Wyeth, Inc.	577, 655

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Physicians seeking locations in Ohio are invited to contact the Physicians' Placement Service in the executive offices of the Ohio State Medical Association, 79 E. State St., Columbus 15. Through this medium efforts are made to establish communications between physicians seeking locations and communities where physicians are needed, or other physicians who are in need of associates.

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WANTED: Resident Psychiatrist or other Physician for private 88-bed psychiatric hospital beginning July 1, 1956. Ohio license required. Write J. H. Nichols, M. D., Medical Director, Windsor Hospital, Chagrin Falls, Ohio.

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GENERAL PRACTITIONER or SURGEON wanted to take over equipment of recently deceased physician in Bellevue, town of 10,000 with surrounding population of farm families and industrial workers; office available at reasonable rent; hospital in town; 12 miles to Sandusky; additional physician needed. Mrs. F. E. Mitchell, 619 Kilbourne St., Bellevue, Ohio, Phone 2-6589.

FOR SALE: Doctor's complete office equipment, including furniture, instruments, books and medicines; all or part. Call or write A. I. Civins, M. D., 634 Osborn Bldg., Cleveland 15, Ohio; or phone MAin 1-8544 or SKyline 1-1191.

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SENIOR STAFF PHYSICIANS—(\$10,314-\$12,152 annually). Vacancy in epileptic hospital, city of 3,500—80 miles north of Detroit, 25 miles east of Saginaw. Vacancy in mental hospital, city of 60,000—135 miles west of Detroit. Two vacancies in hospitals for mental defectives. One in city of 9,000—100 miles west of Detroit. One in city of 11,000 in center of state. These are state positions requiring one year of experience and offering regular working hours, paid annual vacations and sick leave, paid administrative leave to attend professional gatherings, pension plan and many other fringe benefits. Write for application to Recruitment and Placement, Michigan Civil Service, Lansing 13, Michigan.

JUNIOR STAFF PHYSICIANS—(\$9,249-\$10,962 annually). 5 vacancies in mental hospitals. One vacancy in hospital for mental defectives. Vacancies in mental hospitals located in city of 60,000, 135 miles west of Detroit; city of 17,500 in the heart of Michigan's vacation playland, 242 miles northwest of Detroit; city of 7,000, 30 miles east of Grand Rapids, and city of 3,000 in eastern upper peninsula. Other vacancy in city of 6,000, 55 miles north of Detroit. These are state positions requiring no previous experience and offering regular working hours, paid annual vacations and sick leave, paid administrative leave to attend professional gatherings, pension plan and many other fringe benefits. Write for application to Recruitment and Placement, Michigan Civil Service, Lansing 13, Michigan.

WANTED: Physician with dermatological training. Have large practice. Salary to partnership. Box 886, c/o Ohio State Medical Journal.

Tax Court Rules That Physician on Salary Is Primarily an Employee

The U. S. Tax Court has ruled in effect that a physician who receives a salary from a hospital, even though he receives additional compensation, is for federal tax purposes an employee rather than an independent contractor.

The ruling was made in the case of Dr. Wendell E. James, former Akron physician and former director of the clinical laboratory at Peoples Hospital (now Akron General Hospital) from 1948 to 1950. Dr. James sought tax deductions as a contractor because he received a commission out of each out-patient clinical fee in addition to his salary. The court ruled that the hospital had "general control" over his work and that, therefore, the employer-employee relationship existed.

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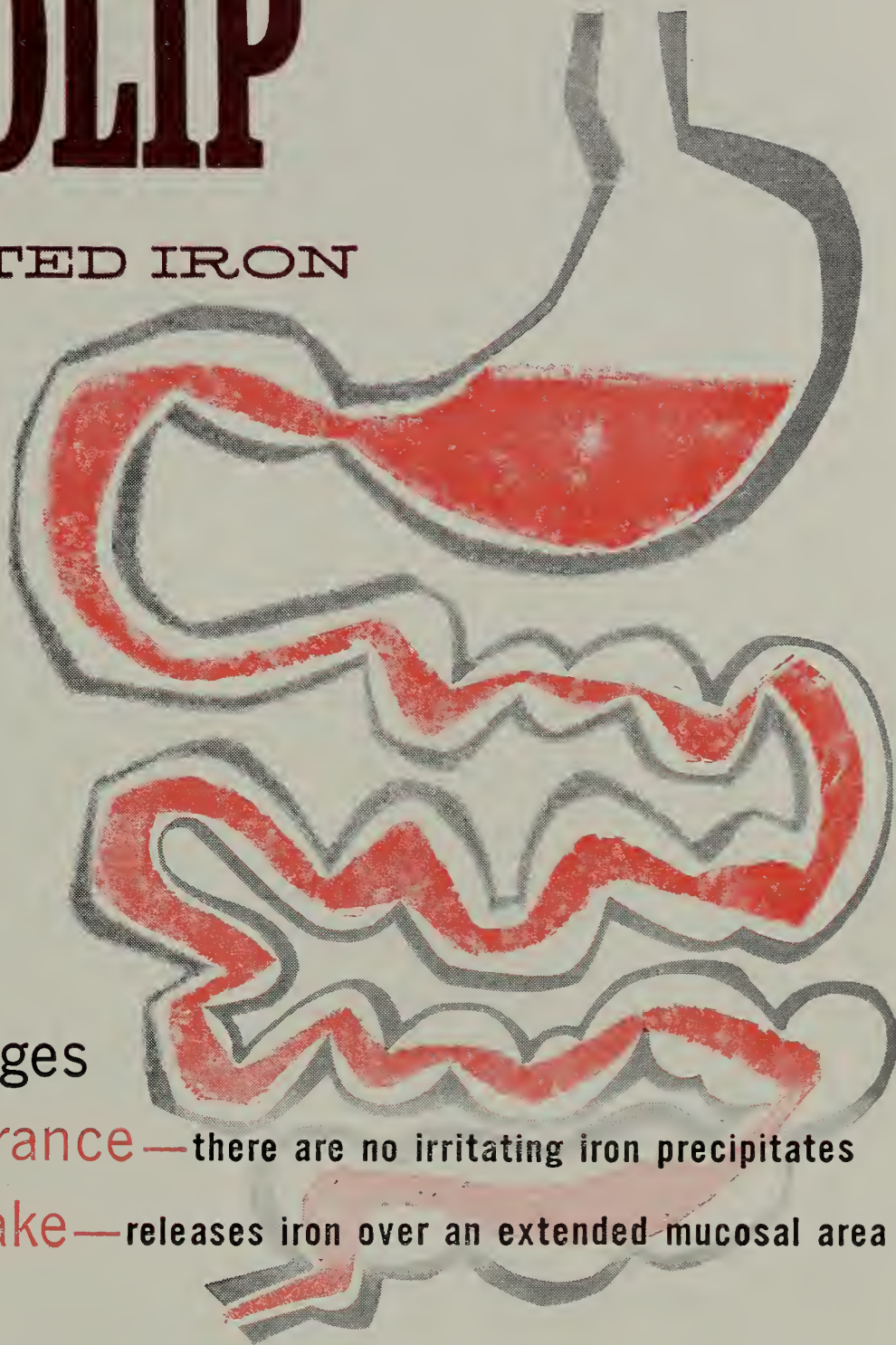
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The Physician's Bookshelf

By JONATHAN FORMAN, M. D.

Doctors' Offices and Clinics, Medical and Dental, by Paul Hayden Kirk and Eugene D. Sternberg, (\$12.00. *Reinhold Publishing Corporation, New York 22, N. Y.*). The practice of medicine is undergoing such rapid changes that anyone planning a new office will do well to study this book. Changes in the extent and arrangement of office space is paralleling the changes in the way each physician now handles his patients.

Many articles have been published in medical periodicals during the last 20 years picturing individual clinics. To find the entire subject covered in a single volume with photographed floor plans, with specifications of construction, heating and air conditioning, in addition to a review of the advantages and disadvantages of the various types of practice, constitutes a valuable contribution to medical economics. Physicians who wish to practice their art and live the major part of their working hours under an ideal environment will welcome the help they can get from this volume.

Functional Otology, The Practice of Audiology, by Morris F. Heller, M. D., (\$5.50. *Springer Publishing Company, Inc., New York 10, N. Y.*). Doctor Heller and his two co-authors meet in this volume the increasing demand for co-ordinated information on this subject. They present every aspect of audiology in a concise, immediately applicable manner.

Practical Management of Disorders of the Liver, Pancreas and Biliary Tract, by John Russell Twiss, M. D., and Elliot Oppenheim, M. D., (\$15.00. *Lea & Febiger, Philadelphia 6, Pa.*). Represents the combined experiences of the staff for years at the old Post-Graduate Hospital in New York. Practicing physicians will therefore find here the concise information they look for in their day's work.

The Hemorrhagic Disorders, by Mario Stefanini, M. D., and William Dameshek, M. D., (\$11.75. *Grune & Stratton, New York 16, N. Y.*), is an attempt to meet the needs of the practicing physician in his quest for useful information. The authors make a "four-legged" stool out of (1) coagulation, (2) vascular, (3) platelet and (4) fibrinolytic mechanisms, thus giving as broad an approach as possible in the search for the missing elements.

Weight Control—A Collection of Papers Presented at The Weight Control Colloquim, Ames, Iowa, (\$2.50. *Iowa State College Press, Ames, Iowa*). These papers represent an attempt to close the gaps in our knowledge by evaluating present information. It therefore belongs in the

library of every physician who undertakes to control the weight of any of his patients.

Behavior and Development in Childhood, by Alfred L. Baldwin, (\$6.25. *The Dryden Press, New York 19, N. Y.*) The author has attempted to explicate a theoretical framework which can be of help in predicting how children behave and how they develop. To clarify, he has made a sharp distinction between child behavior and child development. The fact that children are less competent and less adaptive than adults is not too well recognized by the physician. In this direction the book becomes helpful to those of us who must, whether we want it or not, have a hand in the development of children.

Adrenal Function in Infants and Children, A Report of the 13th M & R Pediatric Research Conference, Under the Chairmanship of L. I. Gardner, M. D., (Apply. *Ross Laboratories, Columbus, Ohio.*) This symposium covers a variety of material from steroid configuration and nomenclature to hyperadrenocorticism, and rheumatic fever.

Cancer and Common Sense, by George Crile, Jr., M. D., (\$2.75. *The Viking Press, Inc., 18 East 48th St., New York 17, N. Y.*). This is an outspoken book which challenges the modern methods of raising funds for Foundations dedicated to prevention, control or cure of specific diseases. The problem of Fear doing harm is often invoked against the campaigns of each of the groups, but your reviewer knows of no evidence one way or the other. One's attitude toward "preventive surgery" or the results of the various therapeutic measures now current is also pretty largely a matter of personal experience. Consequently, it is a highly controversial subject well worth airing in an attempt to get at the facts.

The Casualty Department, by T. G. Lowden, (\$7.50 *E. & S. Livingstone Ltd., Edinburgh and London*. United States Distributor, *Williams & Wilkins Co., Baltimore 2, Maryland*). A practical work covering the modern problem of the accident department of a general non-teaching hospital in an industrial area—a book for every plant dispensary and every accident receiving room.

School Health Sourcebook, by Oliver E. Byrd, M. D., (\$7.50. *Stanford University Press, Stanford, California*). For years we have used the author's **Health Yearbooks** and admired his ability to select and write abstracts. We have also found his **Yearbook on Health and Nutrition** most helpful. For school administrators,

nurses, physicians and public health workers, this will prove a most valuable guide.

Aging and Retirement: A Report on The Fifth Annual Southern Conference on Gerontology, University of Florida, (\$2.00. *University of Florida Press, Gainesville, Florida*). This is a report on the combined meeting of The Gerontological Society, Inc., and the Southern Conference. An excellent set of papers worth their reading by anyone interested in Aging.

Principles of Medical Statistics, by A. Bradford Hill, (\$4.00. Sixth Edition. *Oxford University Press, New York 11, N. Y.*). In clinical medicine there is a growing demand for adequate proof. Often the proof of efficacy of some treatment must depend upon the validity of statistically reliable conclusions. Too often we are given something else. Anyone writing a medical paper involving what appears to be statistical proof should be familiar with the principles laid down in this text.

Bedside Diagnosis, by Charles Seward, M.D., (\$4.00. 3rd Edition. *E. & S. Livingstone Ltd., Edinburgh and London*. United States distributors, *Williams & Wilkins Company, Baltimore 2, Maryland*). A book designed to preserve the traditional approach which cannot be outdated. It will also prove helpful to the student by showing him how the experienced physician has trained himself to seize the essential elements of the diagnostic problem out of a confusing maize of facts and appearances.

Human Pathology, by Howard T. Karsner, M.D., (\$15.00. 8th Edition. *J. B. Lippincott Company, Philadelphia 5, Pa.*). A complete revision of this well-known text. Inflammation now deals with other factors such as those of phagocytosis, ACTH, hyaluronidase and collagen. New material on shock, pathogenesis of fever and revisions in every chapter on Special Pathology.

The National Formulary. (\$9.00. 10th Edition. American Pharmaceutical Association, Washington 7, D. C.; distributed by *J. B. Lippincott Co., Philadelphia 5, Pa.*). This book is well known and furnishes pharmacists and manufacturers specifications for the procurement of drugs used in dispensing, prescription compounding and manufacturing, as well as supplying formulas and working directions for preparation of dosage forms.

Medical Students and Medical Sciences, by David C. Sinclair, M.D., Demonstrator of Anatomy, Oxford University, England. (\$5.75. United States distributor, *Oxford University Press, 114 Fifth Ave., New York, N. Y.*) A discussion of some of the problems of the medical student, especially in Britain and the United States. It deals with such things as selection of students—the way in which they are taught and their progress assessed; the relation of the ap-

plied sciences to the curriculum and the ideas behind some of the experiments in education now being conducted. A stimulating book for all who have an interest in medical education.

Pathology Seminars, edited by Robert S. Haukoohl, M.D., and W. A. D. Anderson, M.D., (\$10.00. *C. V. Mosby Co., St. Louis 3, Mo.*). This book presents five seminars by distinguished pathologists. Three are on tumors, one moderated by L. V. Ackerman, M.D., one by Arthur P. Stout, M.D., and one by Rupert A. Willis, M.D. The seminar on tumors of the nose and throat is moderated by J. E. Ash, M.D. An introduction to the pathology of the skin is moderated by Arthur C. Allen, M.D. These were presented at the Marquette University School of Medicine.

Atopic Dermatitis, edited by Rudolf L. Baer, M.D., (\$2.50. *New York University Press*. Distributed by *J. B. Lippincott Company, Philadelphia 5, Pa.*). Dr. Baer has edited the most helpful text on the subject. He and his associates have cleared up the subject by delineating and defining what it is they are talking about. Sulzberger's discussion of the psychosomatic aspects is, in your reviewer's opinion, the sanest thing that has been said so far in these days of overemphasis on emotional problems. Anyway, if you do not agree, you still must give his viewpoint a hearing in order to defend your own. Pathogenesis by Rostenberg is a most helpful survey. Management makes the book a must.

Mental Health Through Physical Education and Recreation, by Emma McCloy Layman, (\$4.00. *Burgess Publishing Company, 426 S. 6th St., Minneapolis, Minn.*). This is a text on Mental Hygiene designed for teachers of physical education in recognition of the innate relation which exists between the two.

Basic Surgical Skills—A Manual with Appropriate Exercises, by Robert Tauber, M.D., (\$3.75. *W. B. Saunders Company, Philadelphia, Pa.*). Deals with knots, ligatures, stitches and hemostats.

Oral and Dental Diagnosis with Suggestions for Treatment, 4th edition, by Kurt H. Thoma, D. M. D., and Hamilton B. G. Robinson, D. D. S., (\$10.50. *W. B. Saunders Company, Philadelphia, Pennsylvania*). Redesignated now for use as a textbook for the course by the same name. Nevertheless, it is still a book of reference for the practitioner.

The Case History of Sigmund Freud, by Maurice Natenberg, (\$3.95. *Regent House, 4554 N. Broadway, Chicago 40, Ill.*). This is a realistic study of one of the most fantastic personalities of all times. This evaluation accounts for many facts of practical consequence of which the author makes his case against Freud and all of his works.



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The Ohio State Medical Journal

Published under the direction of The Council for and by the members of The Ohio State Medical Association, a scientific society, non-profit organization, with a definite membership, for scientific and educational purposes.

Vol. 52

July, 1956

No. 7

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Loss of Hearing: the Patient and His Problem

RICHARD H. WEHR, M. D., and MARSHALL A. BECKER

TO understand the problems of the person with impaired hearing, we are forced to generalize about some of the dynamics of human behavior, even though the only safe generalizations are that one cannot generalize about people and their personalities, and that each person has a personality which is unique. As we look toward the problem, however, there are certain trends, clusters of facts, which all who deal with the hearing handicapped person must include in their perspective. The first such idea is that hearing is, to a considerable extent, a social, as well as intellectual, "sense." While sound acquaints a person with important activities in the world around him, it also enables him to expand his basic social relationships more easily.

THE DEAFENED CHILD

The infant who is deaf shows no deficit after birth, but before long he begins to lag in social maturity due to his restricted contact with the environment. While intellectual level, as such, is not markedly retarded, except in areas requiring language skills, the personality development is threatened by weakened lines of communication, and the resultant experiences. Frustration due to the inability to make desires known may lead to tantrums, yelling and head banging, withdrawal into the confines of the self, or other behavior problems. Often the retarded social development is taken for the problem, when the real problem is the inability to communicate effectively.

On such a foundation of frustration in communication is often built the problem of heightened feelings of anxiety. We can say that

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anxiety is a phenomenon common to all persons—sometimes as a fleeting experience, sometimes as a phenomenon playing a major role in the development of personality. The hearing handicapped person who develops marked anxiety due to constricted socialization may also develop concomitant feelings of wariness and suspicion of others. The myriad possibilities for misinterpretation, the inability to respond to others, the blank or incredulous looks one receives, all tend to set up a psychic wall which may affect the personality and its relationship to its environment, making wariness or anxiety common reactions to social situations.

Another problem with which the hearing impaired child has to deal is the formation of a negative self-concept. It is as if he says to himself, "My parents (later teachers) act as if there's something wrong with me; so there is something wrong with me." And "wrong" often becomes distorted and expanded to include bad, stupid, undesirable, and so on. Analogously, a child who is classified as a monotone and is

placed in the back of the music class will not often learn to sing. Nonetheless, there is no hard and fast rule. Some children may slough off such negative suggestions with ease, or may even use them to show how much people were mistaken. Unfortunately, the problem of negative self-concept occurs often enough to be seriously considered in dealing with the acoustically handicapped child.

CHILD-PARENT RELATIONSHIP

A further problem which influences the development of the child with the hearing loss is the attitude of the parents toward the child and his problems. While many parents are able to give the child the love and understanding he needs, the discovery of a serious defect sometimes seems to bring out negative feelings on the parents' part. Sometimes guilt feelings at producing a child with such a problem cause a parent to reject the child overtly, or to become oversolicitous and demand unreasonably perfect performance, only dimly masking the true feelings underneath—feelings of which the child is all too often aware.

In such cases the child is the living example which continually reminds the parent of his child's problems and makes him struggle unconsciously with his feelings of rejection toward the child. In this situation, each parent has to work out his own adjustment to his child and his problem. Not infrequently, the father blames the mother, and the mother blames herself, placing the child in the midst of a constant stream of tension flowing between parents and between the parents and the child.

FACE REALITY

Then, too, there are parents who compound the problem by clinging to the hope that hearing can be restored by medical or magical means. They plead for fenestration operation, spines are adjusted, hearing aids purchased without discrimination, airplane rides are suggested, adenoids are invariably removed, all usually with little or no effect on hearing. Slightly more realistic parents may accept the handicap but expect use of a hearing aid to endow the child with perfect hearing, normal speech and language, and no observable handicap. The truth is that in most cases where there is severe loss of hearing, there will always be a handicap. The well adjusted parent aims to help this child become a competent, happy, well adjusted, hearing-impaired person who communicates with relative ease and is comfortable in the hearing world, rather than a poor imitation of a hearing person, always laboring to conceal his handicap, and never succeeding.

Good interpersonal relationships depend on the free flow of communication, the clearing up of areas of misunderstanding, and the opportunity to express one's feelings in an acceptable manner. For the child who has a severe communication

problem, the major avenue of give and take is closed. On the one hand he piles up experiences which make communication seem an unpleasant problem to him, while on the other hand the same difficulty deprives him of many of the acceptable doorways to self-expression.

A COMMON SYNDROME

Thus, keeping in mind the fact that each child develops differently from every other, we may postulate a "hearing loss syndrome" of behavior. In children who have had substantial hearing losses from early life we may find any or all of the following characteristics:

1. Irritability and frustration
2. Anxiety in social situations
3. Suspicion
4. Negative self-concept

It is not enough to know that a child is hard of hearing. It is not enough to recognize the axiom that early detection of hearing loss and prompt medical and educational measures are paramount. Nor is it enough to inform teachers of the hearing loss and see to it that the child is placed in the front of the room or in special school or classes. More than this, we need to know what all these measures mean to the child. A word of interpretation to him and to his peers may be the difference between acceptance and rejection. The right dosage of patience and assurance at the appropriate time is as important as sound discrimination drill or a hearing aid battery. The sensitive person reacting to the needs of the individual knows that the treatment for fear and suspicion is love and acceptance; for irritability, understanding; for the development of a positive self-concept, successful learning experiences and confidence.

In all of this the family plays a primary part, for theirs is the difficult task of accepting the idea that the cardinal objective in the management of the deaf child is the conservation of all possible communication. The most fundamental objective is *not* speech itself, although speech becomes an important means toward realizing the prime end. Rather, socialization to presume the optimal growth of personality is the practical problem. For many deaf persons feel that no one understands them. Their world, they believe, is vastly different from that of others. Before they are very old, many of them are so battered and confused inwardly that the suspicious wall is already built, and the deaf become "us" while the hearing are "them."

All too often families, schools and communities do not recognize the needs of these persons, and moral, rather than objective, judgments are made about behavior problems. This becomes crucial, for the extent of the handicap in any deficiency depends greatly upon the concerned person's conception of his problem as it relates to himself.

Generally speaking, it is a pretty safe rule to say that a child who seems to be deaf should be

treated as such, even though he occasionally seems to respond to the passing of a truck or airplane, the slamming of a door, or a loud shout. And unless special testing should prove otherwise, lack of attention to sound and speech, combined with retarded speech development, should be taken to indicate loss of hearing. For, while mental retardation, aphasia and certain severe childhood emotional disorders may roughly imitate marked loss of hearing, in the majority of cases referral for medical and educational procedures for hearing loss will be proper.

THE ADULT WITH A HEARING PROBLEM

When we approach the problem from the standpoint of the adventitiously deafened adult, several new factors enter the picture. Recently one of the authors (R. W.) spent approximately four hours with an outstanding industrialist evaluating his hearing loss, and testing with and without a hearing aid. The patient later cancelled his appointment with a hearing aid salesman, saying "I'd rather be dead than wear one."

That loss of hearing tends to be followed by personality change has long been known, but the reason for it is far from obvious. There is an almost characteristic depression, often more severe than we would expect from the loss of easy two-way communication. This is true even though language and speech have long been learned and come easily.⁴ Nor is the depression always alleviated by learning lipreading and the proper fitting of a hearing aid, although this assistance to communication is both desirable and helpful. These problems prompt some people to ask, "Is there a special psychology of the hard of hearing and deaf?"

Experience gained from the rehabilitation of servicemen who lost their hearing during World War II has shown that deafness produces a psychological impairment which seems to involve factors other than the communication problem. To understand the problem of the adventitiously deafened, one must make a conscious effort to imagine what it is like to become suddenly and markedly deaf, living in a silent world, cut off from the familiar sounds of every-day living. Imagine a world where everything has the stylistic unreality of pantomime. Think of your own reactions whenever 15 minutes of the audio portion of your favorite television program fails.

BACKGROUND SOUNDS ADD COMPLETENESS

The obvious limitation of the deafened is that he cannot hear the spoken word. He may compensate, to a greater or lesser degree, by learning lipreading and by using a hearing aid. However, without the full range of normal hearing he misses the little asides that add immeasurably to the zest of normal conversation. He is often unable to localize the source of sound. He is constantly forced to supplement his understanding of speech with guesses to fill-in what is

missed. Until their loss occurs, it is impossible to realize how enormously these "little things" contribute to the feeling of group participation.

As living beings, we can never be independent of our environment, and we live in it in varying degrees of security. Since the security is never complete, we maintain a readiness to react, to withdraw or to go forward as the need arises. The primitive function of hearing maintains this readiness to react by keeping us constantly informed of events about us through sound which seldom penetrates to the conscious level. The question, "Why do I feel so depressed, so caught in a dead world?" so frequently asked by the hard of hearing person may be explained as a result of the destruction of the sound coupling which connects the individual at an unconscious level with the aliveness and activity of the world. Undoubtedly the loss of conversation makes the deafened person feel isolated from the world around him, but additional emotional upset is caused by the loss of hearing at this primitive level.

Adequate hearing plays an equally important part as a receptor of signs and signals, giving us knowledge of activities occurring within the range of hearing, such as footsteps, auto horns, doors slamming, etc. Although the eye lets us see in a straight line, adequate hearing lets us hear around corners. It is easier to compensate at this level for lost hearing than it is at the primitive level, since vision or amplification often enables us to recapture some of the signals.

Beyond those two levels, the use of language sets human society apart as unique from the rest of the animal kingdom. Spoken language demands hearing at a level where the symbolic function of speech can be perceived and used. With the use of language, we are able to communicate through a medium which is flexible and manifold, organize our thoughts in a logical and useful order, and to formalize and define the social limits which make up the morals and mores of the group.⁴

Loss of these three functions does not affect every hearing handicapped person equally. A sudden, severe loss of hearing will cause substantial disturbance over the absence of the feeling tone of an active world, of hearing on the primitive level. The gradual hearing loss, on the other hand, will cause less of a problem on the affective level, and more in the area of understanding speech and difficulty in communication. On the whole, the degree of hearing loss, the rapidity of its development and the age of onset are primary in attempting to understand the problem of hearing loss and its impact on the personality.

Frequently an otologist will see hard of hearing patients restored to serviceable hearing by fenestration surgery or the use of a hearing aid. But often the traits and problems attributed to the loss of hearing remain, because they were

not expressions of the handicap but rather expressions of the basic personality. Just as all other persons, the hearing handicapped must be understood as people striving to manage the problems of living. We must consider both the stresses which loss of hearing creates, and the ways in which we can best help the hard of hearing to manage these stresses. Nor can we hope for a single answer, for there will be as many answers as there are people facing the crisis of adjusting to loss of hearing.

CAREFUL COUNSELING IS PARAMOUNT

Each person's reaction to stress is determined by his personality and his way of dealing with the realities of living. And loss of hearing, as an adjustive crisis, has characteristics that make it a difficult one, for many of our needs are met through interpersonal relationships maintained through communication achieved largely by means of spoken language. Consequently, the loss of communication skills is particularly depriving, particularly threatening to the carefully balanced personality structure and to its foundations of security, acceptance and feelings of adequacy.

One observation stands out above all others, and that is that the greatest single factor standing in the way of overcoming such a handicap is the attitude of the person towards himself and his problem. Many will not seek or accept help, but merely brood and limp through life pretending that their loss isn't as severe as it really is. Such an attitude will not contribute toward adequate adjustment.

DISCUSS HIS PROBLEM

In helping to establish a constructive attitude, the hard of hearing person must understand his own specific problem. It is not enough for him to know that he cannot hear adequately. He must recognize the limitations imposed by the handicap. He must learn what he can and cannot expect to be able to do. He should know whether his hearing is likely to get better, become worse or remain stationary. And he must attempt to make the best of the situation and spread his feelings and attitudes out in front of him for self-examination in preparation for the long pull ahead.

More and more we are coming to recognize that emotional factors in the personality may themselves cause deafness. In such cases, where there is no actual change in either the conductive mechanism or the end-organ, and when the nerve impulses are actually transmitted to the brain but not interpreted, the deafness is psychogenic. This is not to be confused with malingering, in which the person knows he can hear but makes a conscious effort to simulate deafness, usually for conscious gain. The functionally deaf person, on the other hand, does not know that he still has hearing, and considers himself truly handicapped.

Primarily through the experiences of aural rehabilitation staffs during World War II, we are coming to recognize that psychic hearing loss is more common in civilian life than has been previously recognized. Although cases of complete psychic loss or malingering are relatively few and far between, we are more impressed with the idea that deafness may well be organic, but may also have a psychic overlay complicating the issue.

While hysterical deafness and psychogenic overlays to organic hearing loss are of overall importance, they are properly the province of the otologist and audiologist in their detection, and of the psychiatrist and psychologist in discovering and treating with the underlying problem. While the otologist can often help in cases of psychogenic hearing loss by giving strong positive suggestions that the hearing will return, the underlying problem may well be severe enough that professional psychiatric aid should be obtained.

ADJUSTING TO THE PROBLEM

What are some of the things which can be suggested as aids in adjusting to loss of hearing? The first step is to encourage the patient to face his hearing loss and accept it, rather than trying to pretend that it doesn't exist. A positive approach toward admitting the existence of a problem is needed, and that includes encouraging the patient to admit when he cannot hear, instead of bluffing. When the person is able to change his position in respect to the speaker, use the available light to help his lip-reading, and do so without being overly self-conscious, he has won a battle. The positive approach also includes emphasizing the forward steps toward rehabilitation which can be taken, and in playing down the "no one will know" idea which is so prevalent in modern hearing aid advertising. A frank admission of the existence of a problem will make speakers, as well as hard of hearing listeners, much more comfortable.

CONTINUE NORMAL LIVING

The second step is to encourage the patient to resume as full a life as possible. The person with a progressive loss will typically give a history of withdrawal from favorite activities, such as movies, church, social clubs, and others, as failing hearing makes it increasingly difficult to keep up with speech. Such patients should be encouraged to pick up as many of the old activities as possible, or to substitute new ones for them. Often the patient is able to resume many of his former pursuits once he is over the initial adjustment, especially if he has a hearing aid. If group activities continue to pose problems in the understanding of speech, other more individualized activities should be substituted. It is vitally important for the hearing handicapped person to be able to become involved with things

outside himself and his problem, as much as for any person with any handicap.

Another desirable aspect of developing and maintaining outside interests is the need to meet the problem of feelings of reference. When we enter a room and conversation ceases, most people will assume that the conversation was about them. These feelings of reference are common to all of us at one time or another, when we interpret outside events as referring to ourselves. Consider, then, the problem faced by the hearing handicapped person who is constantly surrounded by half-heard conversation, unexplicable sudden laughter, and frequent replies of "Never mind, it wasn't important" to requests for explanation. While such feelings of reference will seldom become delusory to such an extent as to be considered truly paranoid, they can lead to strained interpersonal relations with family and friends, and to substantial feelings of insecurity.

Such feelings of reference can be held to a minimum if the person is basically secure and feels that he is accepted by others around him. Further, the person who maintains his interest in the world around him, and in activities and relationships outside himself, will be less likely to develop such unwarranted feelings, and will continue to consider the casual acts and comments of others as relating, not to himself, but to the world around him.

The third step in helping the patient to adjust to his hearing loss is to encourage him to investigate all possible measures to increase his communication ability, including lipreading and a hearing aid. Lipreading instruction should be encouraged as being a helpful tool in understanding speech, and not as a last resort measure for the hopelessly deafened. Hearing aids should be spoken of positively and evaluation of performance with a hearing aid should be an integral part of the examination and testing procedure.

The idea that patients should not buy hearing aids until they are completely unable to get along in conversation should be discredited, and the advantages of easy orientation to amplification while the loss is still moderate should be stressed. Along with this, the misconception that a person with a nerve type of hearing loss is unable to use a hearing aid should be exploded, and replaced with the encouragement to be satisfied with an increase in hearing performance, even though it may not ever approach perfect hearing.

Loss of hearing is a problem which is being attended from all sides. Otologists are not only treating the physical problem, but are counselling with patients at a most crucial time in their lives. Audiologists are developing new testing techniques and are offering special training programs designed to make adjustment to hearing loss as easy as possible. Educators are increasing the scope of training programs for the hearing handicapped child, and electronic en-

gineers, psychologists and researchers are all participating in the attack on hearing loss. With such a team approach, it seems reasonable to forecast a broadening and more intelligent understanding and acceptance of hearing loss.

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The Trapping of Iodide in the Body

Iodine enters the body as iodide through the gastrointestinal tract from which it is readily absorbed from foodstuffs and water. The largest part of this absorbed iodide is excreted in the urine as iodide. Smaller amounts enter the feces, sweat and gastric and hepatic secretions. Traces appear in saliva and milk. It is the function of certain body tissues to remove this iodide from the blood, oxidize it to iodine and combine it within a complex protein grouping. Perhaps many tissues can do this, as is evidenced by the fact that iodine injected intramuscularly results in abscesses containing relatively large amounts of thyroxine.

The chief site of iodide trapping in the human is the thyroid gland. Here the protein complex can be stored and broken down for future release to the blood stream. The thyroid follicle is saturated. This will occur even should agents which prevent binding of iodide in organic form be used, such as thiouracil. The iodide trap operates in the magnitude of 25:1, thyroid to serum. With the use of an antithyroid agent, the ratio may reach 300:1. In Graves' disease, a 350:1 ratio may occur.

The blood level of iodide also acts as a controller of iodine binding, or thyroid hormone formation. A very high level of iodide in the serum inhibits thyroglobulin synthesis. The iodide is merely taken into the follicle and released again as inorganic iodide. In hyperthyroid patients the level of iodide in serum which accomplishes this depressing effect is less than that required in normals.—Howard J. Wetstone, M. D., and Joan Stiano, B. S., Hartford: *Connecticut State M. J.*, 20:345, May, 1956.

Tuberculin Tests are valuable in diagnosis, to determine the status of tuberculosis control in a community, and perhaps as a screening tool in case-finding. Although several techniques are in use, the intradermal test with P. P. D. is preferred. Patch tests can be used successfully but have definite disadvantages.—Floyd M. Feldmann, M. D., New York: *NTA Bulletin*, November, 1955.

Indications for Surgery in Mitral Stenosis

EARLE B. KAY, M.D., and FREDERICK S. CROSS, M.D.

WHEN in the natural history of rheumatic heart disease significant stenosis of the mitral valve arises, or whether it arises at all, is unpredictable and variable. Consequently, the advisability of surgical intervention must be considered on the basis of the following fundamental factors:

1. The natural history and course of the disease.
2. The risks of surgical intervention.
3. The results of surgical intervention.
4. The opportune time for surgical intervention.

A sufficient number of survival studies have been carefully performed (table 1) to demonstrate that patients with rheumatic heart disease fall roughly into three groups, i.e., those whose cardiac status remains benign and unchanged, those whose disability slowly progresses, and those whose disability rapidly progresses to morbidity and death.

Rheumatic heart disease has been considered a disease of young adults but it is apparent that it involves all age groups. Some patients die during childhood, some during middle-age, some at old age, and in others it never becomes clinically significant. (Table 2.)⁵

The death rate from rheumatic heart disease was 14.8 per 100,000 in 1950 as compared to 20.4 in 1944. With the advent of the antibiotics there has been a steady improvement in the prognosis of rheumatic heart disease. Such data does not include those patients with benign as well as significant rheumatic heart disease who died of other causes. Nor does it reflect the duration of morbidity prior to death. Even though it is apparent that many people with rheumatic heart disease will live to middle or

From the Surgical Service of St. Luke's and St. Vincent Charity Hospitals.
Submitted January 11, 1956.

TABLE 1—SURVIVAL STUDIES IN PATIENTS WITH RHEUMATIC FEVER AND RHEUMATIC HEART DISEASE

Cohn-Lingy ¹ 1943, N. Y. C.		{	50% dead less than 9 years				
3,129 patients—onset to death			25% dead 17+ years—Av. 13 years				
			10% dead in 30+ years				
Wilson-Lubschez ² —1948, N. Y. C.	226 Deaths				{	80% — 15 years	
1,042 Children	21.8%			Survival		75% — 20 years	
30 year period—Average 14.8 years			Expectancy	66% — 30 years			
						50% — 40 years	
Grant ³ —England		{	1/3 Unchanged				
1,000 Ex-soldiers	Decade 30 — 40		1/3 Progressed				
			1/3 Dead				
Bland—Jones ⁴ — Boston, 1951		{	16% (108 of 653)				
1,000 children—20 years	1/3 Dead		Rh. F.			Rh. H. D.	Normal
Average age at end—28 years	20 years		44.4% (157 of 347)				
			Rh. F.			Normal	M. S.

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even old age, there is no justification for such patients to die prematurely from rheumatic heart disease any more than they should from malignancy, if it is possible to prevent their untimely death by surgical intervention.

There have also been a number of valuable studies correlating the clinical and pathological findings of patients dying from rheumatic heart disease.^{6, 7, 8} One of the more important of these was the analysis of Graham, Taylor, Ellis, et al.⁹ Table 3 taken from their study showed the cause of death, average age and degree of stenosis in 101 patients who died from mitral stenosis and were autopsied.

Approximately 50 per cent of these patients dying from heart failure and embolic phenomena had high grade (Grade 3) mitral stenosis. The duration of time during which lesser degrees of mitral stenosis existed must also be taken into consideration as playing a contributory role in the production of morbidity and death. There was also a correlation between the degree of mitral stenosis and the degree of pulmonary vascular changes; those patients having the greater degrees of mitral stenosis were for the most part also the ones demonstrating the greater degrees of pulmonary arteriolar sclerosis. From

this study they concluded that mitral stenosis was an anatomic obstruction which could be well tolerated by many persons for a long period and that its presence was often compatible with a relatively long life, yet it was equally obvious that ultimately almost all patients died as a consequence of their disease.

From the foregoing evidence, survival rates, mortality figures, and autopsy correlations characterizing the natural history of rheumatic heart disease, one can generalize that people with this disease may:

1. Run a benign course and never develop clinically significant rheumatic heart disease.
2. Die prematurely from rheumatic heart disease.
3. Not be significantly disabled from rheumatic heart disease until their later years of life.

It is this second group who die prematurely from their rheumatic heart disease in the form of valvular incompetence, and specifically for this discussion from mitral stenosis that one's attention is focused toward benefitting by surgical intervention. It behooves the clinician to follow his patients with mitral stenosis sufficiently carefully and with sufficient data to be able to determine their course with sufficient accuracy so as to know the opportune time for operation.

PHYSIOPATHOLOGY OF MITRAL STENOSIS

Rheumatic heart disease is a chronic pancarditis. There are relative degrees of pericarditis, myocarditis, and impulse transmission defects that are variable, changeable, and unpredictable. The role of the cardiologist is to evaluate each of these factors contributing to the disabled patient, to relegate to each its proper place, and to determine their relative significance in the production of signs and symptoms. The role of the surgeon is to relieve the mechanical obstruction to blood flow through the mitral valve. Fortunately, anatomically the mitral valve in mitral stenosis lends itself to surgical correction in the majority of instances.

The gradual reduction in the size of the mitral orifice is largely the result of progressive obliteration of the commissures between the valve cusps. In addition there may be absorption and contraction of the scarred valves with eversion into the ventricular chamber and matting with the chordae tendinae. The salient feature however is the presence of a normal ring of valve substance between the rheumatoid involvement of the cusps and the mitral annulus into which the fused commissures are opened.

THE SELECTION OF PATIENTS FOR CARDIAC EVALUATION STUDIES

Patients are selected for cardiac evaluation who have manifested signs or symptoms of

TABLE 2—DEATHS FROM RHEUMATIC FEVER
CONTINENTAL UNITED STATES 1950 BY AGE

Age	Number of Deaths
Under 5	83
5 - 14	716
15 - 24	1,019
25 - 34	1,861
35 - 44	3,322
45 - 54	4,171
55 - 64	4,384
65 - 74	3,531
75 - 84	2,424
85+	805

TABLE 3.—CAUSE OF DEATH IN PATIENTS
DYING FROM MITRAL STENOSIS

Cause of Death	No.	Av. Age	No. with Grade 3 Stenosis (high grade)
Heart Failure	44	50	21
Embolic phenomena	33	56	18
Pulmonary emboli	11	45	4
Pneumonia	6		2
Other causes	7		2

progressive cardiac impairment. Persons with a murmur from previous involvement of the mitral valve without significant signs, symptoms, or disability, who have a benign form of the disease and whose valvular stenosis does not appear significant or progressive, obviously do not require an extensive cardiac diagnostic study, and certainly do not require surgery. The operation is designed to relieve the mechanical obstruction to the mitral valve. It does not restore the valve to normal or eradicate the other damage resulting from rheumatic fever. Furthermore, the disability must be primarily the result of mechanical obstruction and not cardiac failure from a chronic myocarditis. Such patients should be evaluated only after one is sure that the acute myocardial failure superimposed on a chronic myocarditis has subsided.

The transition from insignificant nonobstructive mitral stenosis to significant obstruction is not rapid. One has an ample opportunity to follow and evaluate such patients prior to surgical consideration. However, on the other hand, once mechanical obstruction of a significant degree has developed it is unwise to allow that patient to progress to frank failure before surgical intervention is considered. There is an opportune time for surgery. It is impossible to obtain a good result if the patient has been allowed to deteriorate to a point where there is no return regardless of the excellency of the valvuloplasty.

OPERATIVE INTERVENTION

Sufficient studies are now available on the progressive course of symptomatic mitral stenosis toward morbidity and premature death to make operative intervention desirable. The risk of operation is negligible as compared to the ultimate fate of untreated cases. In experienced hands the operative mortality is approximately 3 to 5 per cent in Group III patients and 10 to 20 per cent in Group IV patients. In the last

86 patients operated upon, there has been only one death and that was a Group IV patient. Also, there has been no embolic phenomena even though 15 per cent of the patients have had thrombosed auricular appendages and 10 per cent have had calcified valves. With this low an operative mortality and with the proper selection of patients, one does not hesitate to recommend surgery in those patients needing it. Furthermore, the benefit derived in our series has been better than 80 per cent. The foregoing amply answers and satisfies the criteria for surgical intervention.

The one remaining question is when, in the course of progressive mitral stenosis, is the opportune time for surgical intervention? This can be decided only after the careful evaluation of the patient with symptomatic mitral stenosis. Cardiac evaluation is indicated if a patient exhibits:

1. Increasing dyspnea on exertion.
2. Progressive ease of fatigue.
3. Cough unexplained on other basis.
4. Hemoptysis unexplained on other basis.
5. Peripheral embolic phenomena.

Such patient's signs, symptoms, and clinical course are carefully evaluated. Electrocardiographic studies are performed. Roentgen and fluoroscopic examinations are taken in the various projections to determine chamber enlargement, pulmonary vascularity, and enlargement of the left auricle. Cardiac catheterization studies to determine right ventricular and pulmonary artery pressures, the cardiac output, the response to exercise, and to eliminate other valvular defects, are not essential in all cases but are particularly helpful in the early case to be absolutely sure that significant mechanical obstruction to the mitral valve exists, to differentiate pulmonary hypertension resulting from mitral stenosis from that resulting from myocardial failure, and in the far-advanced patient as prognostic aid. Pulmonary function studies are also helpful in the advanced patient to determine the degree of damage to the pulmonary vasculature and anticipated prognosis.

INDICATIONS AND CONTRAINDICATIONS TO SURGERY

Operation is recommended if after these examinations the following criteria are satisfied and there are no contraindications:

1. Progressive symptomatic mitral stenosis.
2. EKG—Usually right axis deviation.
3. Barium swallow—enlarged left atrium.
4. X-rays—increased pulmonary vascularity.
5. Cardiac catheterization.
Elevated right ventricular pressure
Elevated pulmonary artery pressure
A reduced cardiac output.
Further elevation of right ventricular and pulmonary artery pressure and a fixed cardiac output with exercise.

In addition to the general contraindications to any surgical procedure, the specific contraindications to mitral commissurotomy are:

1. Evidence of rheumatic activity.
2. The presence of subacute bacterial endocarditis.
3. Evidence of predominately myocardial failure rather than valvular mechanical obstruction.
4. Multi-valvular defects (relative).
5. Predominately mitral regurgitation.
6. Not contraindications: Age, Atrial fibrillation; Embolic phenomena; Minimal involvement of other valves; Valvular calcification.

In reference to rheumatic activity and evidence of subacute bacterial endocarditis, such patients may subsequently be candidates for surgery if they otherwise meet the criteria for operation. This would also be true with patients with myocardial failure superimposed upon the strain of valvular obstruction after such failure had been successfully treated and subsided. In Group IV patients, it may be impossible to eradicate all of the evidence of chronic passive congestion. However, the patient must at least be stabilized.

In reference to the association of mitral regurgitation, one cannot always predict the presence or relative significance of an associated mitral insufficiency preoperatively. The problem of the surgical treatment of pure mitral insufficiency is a topic in itself, and will not be discussed here. Relative degrees of mitral insufficiency are not contraindications to mitral commissurotomy and in many instances may be even improved by liberating the fused valve cusps. It is important that in the performance of the operation it be done in such a manner that further insufficiency is not produced.

Frequently, the question of re-closure of the valve with recurrence of symptoms is raised. Experience to date has demonstrated that this is improbable. Fortunately, as previously mentioned, there is an area of normal tissue between the fused commissures and the mitral annulus in mitral stenosis that allows the surgeon to separate the commissures, open the stenosis, and restore valve function without interfering with the mitral annulus, or producing mitral regurgitation.

Occasionally, in a certain percentage of patients (10 to 20 per cent) the valve is so scarred and calcified that this rim of normal tissue is so narrow, or the valve is in the shape of a truncated cone in which the deformed valve cusps are fused with the ventricular endocardium, and matted with the scarred shortened chordae tendinae to such a degree that the valve is only partially opened. Initial improvement in such patients undoubtedly is due to the associated bed rest and psychological factors. Recurrence of symptoms after initial improvement is more

likely due to the following factors than to the development of re-stenosis:

1. Valve incapable of being opened initially (1 to 5 per cent).
2. Valve partially opened (10 to 20 per cent).
3. Recurrence of rheumatic activity (2 to 3 per cent).
4. Presence of, or progression of other valvular disease.
5. Irreversible pulmonary hypertension.
6. Clinical deterioration without regard to stenosis.

PROGNOSIS

The prognosis to be anticipated following operation can frequently be determined in advance and depends largely upon four main factors, three of which may be controllable to a certain extent. The first is the status of the valve, i.e., the degree and extent of the deformity, and the presence, amount, and distribution of calcification. This factor is a reflection of the rheumatic infection and has been in the past uncontrollable. The second and third factors are the status of the heart and the status of the patient. These are to a certain extent controllable and are dependent upon when in the natural course of the mitral stenosis a patient seeks medical attention and the wisdom with which medical attention is administered by the clinician. The fourth factor is the status of the surgeon, i.e., his knowledge, ability and experience.

More specifically the prognosis depends upon the presence or absence of: 1. The degree of stenosis in proportion to the insufficiency. 2. The type and degree of valve involvement. 3. The presence or degree of chronic myocardial damage and insufficiency. 4. The presence and degree of pulmonary arteriolar sclerosis. 5. The presence and significance of multi-valvular defects. 6. The age of the patient, the duration of significant obstruction, the severity of the process. 7. Generalized effects of chronic passive congestion.

In conclusion, patients with progressive symptomatic mitral stenosis die prematurely. The risk of operation and the results of surgery in properly selected cases are excellent. Many poorer risk patients may also be helped. Perhaps more of this group could be helped if surgery had been performed earlier in the course of the disease once significant obstruction has developed. A small group of patients, because of the anatomical characteristics of their valves and other associated factors, will remain unbenefitted by surgery.

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Pitocin® Drip To Accelerate Labor In Effort to Overcome A Uterine Inertia

Primary uterine inertia consists of inadequate, ineffectual contractions from the very onset of established labor. Secondary uterine inertia consists of inadequate, ineffectual contractions supervening on a labor pattern that has, a short time prior, been considered adequate. . . . If a uterine inertia is diagnosed early, a preliminary rest period can be omitted, and normal labor analgesia continued.

Intravenous pitocin® is currently our most expedient ally. The mechanical apparatus should consist of a Y-tube infusion setup with normal fluids in one flask and a pitocin® solution in the other. The pitocin® concentration should not exceed 1:2000 (or 2.5 units or 0.25 cc. in 500 cc.). The rate of flow should be started at 20-30 drops per minute. Once the rate has been stabilized and good uterine contractions are observed, further sedation may be offered. I have been employing demerol® by intravenous drip in conjunction with the pitocin® drip. Here, 200-300 mg. demerol® are placed in the flask with the pitocin®. Providing the rate of pitocin® infusion doesn't have to be made too rapid, there will be no respiratory depression from this amount of demerol®.

The pitocin® is continued until the contractions are effective and remain so, but are not tetanic. If the latter becomes apparent, the pitocin® bottle is clamped and the other opened. Almost always, the pitocin® infusion must be continued to maintain adequate and effective contractions. Because the exhibition of pitocin® occasionally makes a uterus refractory to postpartum tonus, the pitocin® drip should be continued for the first postpartum hour. The concentration frequently has to be increased to as much as 1:200 in this event. Because of this predilection for the postpartum uterus to relax, known as atony, not only with instances of pitocin® drip but with inertia and prolonged labor as well, these patients should have whole blood available.—J. O. McCall, Jr., M. D., Portland, Ore.: *Northwest Medicine*, 55:282, March, 1956.

Acute Myocardial Infarction

An Analysis of 234 Cases

M. P. SAMBHI, M.D., and HENRY A. ZIMMERMAN, M.D.

IN RECENT years, numerous studies have appeared in the medical literature dealing with certain aspects of acute myocardial infarction. Most of these studies pertain to the treatment of this condition. In earlier studies, the figures reported regarding the incidence of this condition vary a great deal. Bland and White¹ (1936) in a series of 461 cases reported the incidence of myocardial infarction to be greatest in the sixth decade of life. Mintz and Katz² (1947) published an analysis of 572 cases of acute infarction. This incidence of acute myocardial infarction in their series was highest in the seventh decade of life.

In the same publication, the ratio between males and females afflicted with acute myocardial infarction was reported as 1:2.2; while Parkinson and Bedford³ (1928) and Bland and White⁴ (1941) reported the same as 1:6.

The mortality figures for acute myocardial infarction have varied widely, too, in different studies. Wooten and Associates⁵ (1952) reported a mortality rate of 43 per cent in 250 patients who had their first attack of myocardial infarction and were not treated with anticoagulants. Master⁶ (1936) reported a mortality figure of 8 per cent.

There are many factors including different approach in methods of study which, in part, can account for these variations. For this reason, a study like ours does not lend itself to comparative statistical evaluation and hence it is not our purpose to compare this with any other series. We had no preconceived ideas about the results of this study and we were simply interested in a study of a group of patients treated in one hospital.

MATERIAL

From January, 1950, to July, 1955, all cases of coronary artery disease admitted to St. Vincent Charity Hospital were reviewed and analysed. Only proven cases of acute myocardial infarction were selected from this group. These cases were proven either by autopsies or serial electrocardiograms. Presence or absence of fever, elevated sedimentation rate or C reactive protein wherever available were taken as additional criteria for support of the diagnosis.

Cases of coronary artery disease manifesting acute or chronic insufficiency were not included in the series. All cases with no electrocardiogram, even with typical or suggestive history of

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myocardial infarction, or with single, doubtful, or borderline serial records, were discarded. The number of cases thus acceptable was 234. About an equal number had to be discarded since they could not meet our criteria for inclusion.

Decades	3rd	4th	5th	6th	7th	8th	9th
Total No. of patients	1	6	43	94	59	30	3
No. of females	x	1	2	10	16	6	2

As regards age, the patients in our series varied from 28 years of age to 82 years. The incidence for acute myocardial infarction rose to a peak in the sixth decade in the males. In the seventh decade, the incidence, although higher than in the fifth decade, was only about $\frac{3}{4}$ of those cases in the sixth decade. However, in the females, the maximum incidence occurred in the seventh decade. In the ninth decade, two out of three cases were females.

The total number of females was 37 out of 234 cases, a percentage of about 15 per cent and ratio of 1:6.6 as compared to males.

PREDISPOSING DISEASES

History of previous coronary artery disease, either anginal pains or previous attacks of coronary occlusions or myocardial infarctions, was available in 31 per cent of males and 50 per cent of female patients.

The history of previous hypertension and diabetes is more interesting as regards to sex incidence. This history was present in a total of 46 patients, 20 of whom were females. This constitutes about 70 per cent of total number of female cases. These had either hypertension or diabetes to account for their coronary artery disease as a contrast to only 12 per cent among the males having a similar history.

LOCATION OF INFARCT

Location of infarcts in these 234 cases according to electrocardiographic diagnosis were as follows:

Submitted October 20, 1955.

Posterior	81
Anterior	114
Subendocardial	21
Antero-Posterior	6
Apico-Septal	3
Septal	3

The ratio of anterior and posterior type of infarcts was found to be the same in both sexes.

MORTALITY

Overall mortality was 19 per cent in these 234 cases proven by either electrocardiograms or autopsy. The patients who died within a short period of time before an electrocardiogram could be taken and an autopsy was not granted have been excluded from the series as pointed out before. The total number of deaths was 45. Eleven of these were females, thus giving a mortality percentage of 29.8 per cent for females and 17.2 per cent for males.

The percentage of mortality in cases of anterior infarctions was significantly higher than posterior infarction as seen below:

Type of Infarct	No. of Deaths	Females	Males	% of Total
Total	45	11	34	19%
Anterior Infarcts	28	5	23	24.4%
Posterior Infarcts	13	4	9	16%
Subendocardial Infarcts	4	2	2	x

It is also clear from the foregoing that females formed a proportionately larger bulk among fatalities from posterior infarcts.

Decades	5th	6th	7th	8th	9th
Males	8	10	11	6	1
Females	1	x	6	x	2
Total	9	10	17	6	3

Mortality rate as seen in the foregoing is maximum in the seventh decade, and this is true for both males and females. The majority of females in later age periods is striking. Thirty per cent of the total number of deaths occurred within 24 hours of admission. The rest are tabulated in the following table:

Time of Death	No. of Deaths	% of Total
Less than one day	13	30 %
Less than three days	7	15.5%
Less than one week	11	23.5%
Less than two weeks	10	22 %
More than two weeks	4	9 %

ARYTHMIAS

Thirty-eight percent of all cases had one or another type of arythmia shown by electrocardiogram at one stage or the other. The rest of the cases were described as normal sinus rhythm. Arythmias occurred with the following frequency:

Type of Arythmias	No. of cases	% of Total
I = Ventricular Extra-systoles	22	26%
Extra-Systoles Supra-ventricular extra-systoles	8	9.3%
II = Supra-Ventricular Tachycardia	12	14%
Sinus Tachycardia	16	18.5%
Tachycardias Ventricular Tachycardia	5	5.8%
Auricular Fibrillation	5	5.8%
Sinus Arythmia	1	1%
Right Bundle Branch Block	17	19.8%
Left Bundle Branch Block	14	17.4%
III = Complete A-V Block	5	5.8%
Blocks Inccomplete A-V Block	13	15.8%

SYMPTOMS ANALYSIS WITH PARTICULAR REFERENCE TO PAIN

On careful analysis of presenting symptoms on admission of these cases of acute myocardial infarctions, they could be divided into four distinct groups.

(1) Those in whom pain was by far the most prominent presenting complaint associated with dyspnea.

(2) Those in whom pain as such was denied but was described as a closely similar but different subjective sensation.

(3) Those in whom pain was entirely masked by another presenting symptom or subjective feeling.

(4) Entirely symptomless or silent cases.

Group 1 contained 206 cases presenting pain in the chest with or without radiation with dyspnea or orthopnea of varying degree.

Group 2, the cases who denied pain, described their discomfort as follows:

Symptoms	No. of cases
Vague discomfort in chest	2
Dizziness or weakness	2
Oppression or sense of heavy chest pressure	4
Heart burn	12

Group 3, the cases in whom pain was entirely masked by other symptoms were of the following two categories: (1) Fainting and collapse, four cases; and (2) Shortness of breath and weakness, twelve cases.

While the reason of collapse masking the pain is obvious, the second category is of special interest because 70 per cent of these cases had either left or right sided heart failure, incidence of two being about equal. As a contrast, only 5 per cent of cases of Group 1 with obvious pain were in cardiac failure.

	Total	No. in Cardiac Failure	Per cent
Total in Series	234	19	8%
Group 1 with pain	206	11	5%
Group 2 with dyspnea but no pain	12	8	66%

Group four—three cases of acute myocardial infarction, proven by electrocardiograms and other supporting diagnostic criteria, were recorded in whom there were no symptoms of any kind at all on very careful inquiry about history, and who were accidently discovered to have myocardial infarctions on routine electrocardiogram examinations. These were called silent cases and are being reported in a separate publication.

AUTOPSY FINDINGS

Thirty-one per cent of total deaths went to the autopsy room. All autopsies revealed infarctions of the left ventricle and septum. There were no cases of infarctions of the wall of the right ventricle or auricular wall in this series. However, auricular appendage was involved in two cases.

Old myocardial infarcts were seen in 50 per cent of the cases. Their locations were as follows: Three anterior, three posterior, and one septum. Mural thrombi on the wall of the left

ventricle occurred in four cases. Two cases of rupture of papillary muscle were seen. Four cases of aneurysmal dilatation of the wall of the left ventricle were noted, one of which had an antemortem rupture of the lateral wall of the left ventricle leading to intra-pericardial hemorrhage and cardiac tamponade.

Realizing that the total number of autopsies is too small to be statistically significant, it is hardly possible to draw any conclusion on incidence of any of the foregoing. These are, however, tabulated below.

Autopsy Finding	No. of cases	Percentage
Old Infarcts	7	50 %
Mural Thrombi	4	29 %
Ruptured Papillary Muscle	2	x
Aneurysm Formation	3	x
Rupture of Ventricular Wall	1	x
Infarcts in Auricular Appendage	2	x

CORONARY VESSELS

Distribution of coronary arteries grossly was remarkably constant in all autopsied cases as shown by the following table:

Vessel Occluded	Area Infarcted
Right coronary artery	1/2 Posterior—1/2 lateral, 1/2 Basal portion of left ventricle
Anterior Descending Branch of left coronary artery	Anterior, lateral and apical portion of left ventricle including 1/3 to 2/3 anterior-portion of the septum and anterior papillary muscles
Circumflex Ramus of left coronary artery	1/2 posterior, 1/2 lateral, 1/2 basal portion of wall of left ventricle with posterior 1/3 of the septum.

Incidence of occlusion of these vessels was as follows: Right coronary, six; anterior descending ramus of left coronary, six; and circumflex ramus of left coronary, five.

The pathology of occlusion was found to be as follows:

- 1. Stenosing arteriosclerosis 2
- 2. Remote occlusion and obliteration 2
- 3. Thrombosis, recent, old, organizing, or recanalized 4
- 4. Atherosclerosis 4
 - (a) Atherosclerotic occlusion 2
 - (b) Hemorrhage in atheromatous plaque 1
 - (c) Ulcerated atheromatous plaque 1
- 5. Subintimal hemorrhage in vessel wall 1

CO-INCIDENCE OF THROMBOSIS AND INFARCTION

Recognizing the obvious limitations of above number of autopsy studies to speak in a statistical way, it was interesting to note how often thrombosis and infarction were found independently of each other.

It was found that nine myocardial infarctions had occlusions of a corresponding vessel to account for them. In six other infarctions found post mortem, no corresponding recent occlusions of a vessel could be demonstrated. These cases fall in a category of myocardial infarctions without complete demonstrable occlusion of the vessels.

In five other cases, there were demonstrable

complete occlusions of the coronary vessels, but no myocardial infarctions were revealed on closely sectioned examination of heart muscle. There were cases of coronary occlusions without myocardial infarction, where either death followed too soon following occlusions of a vessel and there was no time for development of an infarct or the collateral circulation was enough to prevent one.

ELECTROCARDIOGRAPHIC FINDINGS CORRELATED WITH AUTOPSY REPORTS

In 10 cases out of 14 that were autopsied, the autopsy confirmed the electrocardiographic diagnosis rather closely. In the following four cases, a portion of electrocardiographic diagnosis was contradicted by autopsy.

1. Recent anterior infarction was diagnosed on electrocardiogram which was not confirmed on autopsy. There was recent coronary occlusion without infarction to explain the clinical story and there was an old posterior infarction and aneurysmal dilatation of apical portion of left ventricle to account for the mistaken electrocardiographic diagnosis.

2. On two cases an electrocardiographic diagnosis of recent anterior infarction was made. The autopsy revealed these to be recent posterior infarctions superadded to old posterior infarcts.

3. On the fourth case, a recent thrombosis without infarction superadded to an old posterior infarction was electrocardiographically diagnosed as recent anterior infarctions.

In these 10 cases showing a good correlation between electrocardiographic and anatomical findings, nine were uncomplicated by old infarcts. In the tenth case, the correct electrocardiographic diagnosis of old posterior and recent anterior infarction was made antemortem.

The presence of an old posterior infarct thus tends to confuse the electrocardiographic diagnosis.

DISCUSSION

Katz and his associates in their recent book on experimental atherosclerosis (1953)⁷ have pointed out the protective influence of estrogens on development of human atherosclerosis. They have shown by animal experiments that out of alpha and beta lipoproteins, it is the latter which is concerned with the development of atherosclerosis and is elevated in human beings suffering from this disease. Estrogens bring about a decrease in B lipoproteins and increase in the variety. Diabetes and menopause have opposite effects. Hypertension per se was shown to favor atherosclerosis in the vessels subjected to increased pressure in chicks.

Our finding that a great majority of female patients in our series had either diabetes or hypertension and others belonged to a later period of menopause when influence of estrogens had been withdrawn for several years, are in accord with the foregoing.

Infarction of right ventricular wall is known

to be very rare. Whether this is due to the comparatively thin wall of right ventricle as suggested by Blumgart (1940)⁸ or a better collateral circulation, or the presence of thebesian veins in relative abundance, remains to be determined. Wartman and Hellerstein (1948)⁹ reported four infarcts confined to the right ventricle out of a total of 235 myocardial infarcts. We found no instance of infarction in the right ventricle in our series.

It is of further interest to note that in our series all cases that came to the autopsy room could be classified as left coronary artery predominant type in distribution according to Schlesing (1940).¹⁰ This forms an indirect and suggestive evidence for the fact that the right coronary predominant type carries a much better prognosis as compared to the left.

The frequent occurrence of both coronary thrombosis and myocardial infarction independently of each other and resulting divorce of their synonymous usage is well known now. Blumgart and his associates (1941)¹¹ pointed out the occurrence of coronary occlusions with no resultant myocardial infarction. In these cases they believed the collateral circulation was enough to avoid the development of necrosis and infarction of the muscle supplied by the occluded vessel.

The occurrence of myocardial infarction without complete occlusion has been somewhat disputed. Beans (1938)¹² in a series of 300 myocardial infarctions reported that 20 per cent of them were associated with arterial narrowing alone and no occlusion. Friedberg (1939),¹³ in a series of 1,000 autopsies, found that 31 per cent of the myocardial infarcts were not associated with any recent occlusion. Karsner (1949),¹⁴ however, states that he has not seen myocardial infarction without organic occlusions of coronary vessels.

There were two cases in our series of autopsies where no occlusion could be demonstrated of the corresponding coronary vessel but there was a recent occlusion of another neighboring vessel. These we feel represent the cases of "ectopic infarctions," (Bean, 1938, and Blumgart, 1939)^{15, 16} where the blood supply of the infarcted area had been taken over by a collateral channel previously.

The occurrence of intimal hemorrhage as a cause of coronary occlusions had been recognized by Paterson in 1936.¹⁷ He later (1938) reports it to be the commonest pathology responsible for occlusions. Succeeding workers have varying opinions. How frequently it is a cause for thrombosis remains to be determined. The controversy has mainly involved the type of hemorrhage. Drury (1954)¹⁸ in a recent article points out the capillary hemorrhage as believed earlier is seldom responsible for occlusion of a vessel. According to him, intimal rupture due to necrosis is the commonest cause of hemorrhage and thrombosis inside of the vessel.

Amongst the fatalities in our series about 30

per cent died within 24 hours. These cases had varying degree of accompanying shock. Amongst the remaining cases, complications like ruptured papillary muscle, ruptured aneurysm of the ventricular wall with resulting hemopericardium and cardiac tamponade were seen.

CONCLUSION AND SUMMARY

1. The greatest incidence in male population of acute myocardial infarction occurred in the sixth decade. The females had a higher incidence in the seventh decade. Ratio between males and females was 1:6.6.

2. Seventy per cent of the females having acute myocardial infarction had a previous history of either diabetes or hypertension.

3. The mortality figures were maximum in the seventh decade for both males and females. Mortality from anterior infarction was significantly higher than posterior infarction. Females formed a high percentage among fatalities from posterior infarction. It is difficult to evaluate this statistically.

4. Ventricular irritability shown by extra beats or tachycardia and various kinds of conduction defects are commonest arrhythmias accompanying acute infarction of myocardium.

5. Pain is the presenting symptom in a majority of cases. In a small proportion it may be described differently or masked by collapse of acute dyspnea. In the latter case, the majority of patients have cardiac decompensation. Completely silent cases occur but are very rare.

6. The presence of an old posterior myocardial infarction tends to confuse the electrocardiographic diagnosis of recent anterior infarction of myocardium.

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Clinical Trial of Penn Test For Cancer

An independent clinical trial of the Penn sero-flocculation test for cancer was carried out in order to learn whether this test might be clinically useful either in differential diagnosis or as a screening test for the detection of cancer. In addition, studies were made of the flocculation titer of sera giving positive Penn tests. Incidental observations were made concerning the reproducibility of the test.

The trial provided no evidence that the test might be useful in cancer detection.

The test should be improved technologically before further clinical evaluations are undertaken.

Further study of the basic mechanisms that bring about the positive Penn reaction appears desirable.—Robert A. Blossom, M. D., Frederick J. Moore, M. D., and Edward M. Butt, M. D., Los Angeles: *California Medicine*, 84:79, Feb., 1956.

Evaluation of Combined Prednisolone-Aspirin Therapy In the Treatment of Arthritis

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RECENTLY attention has been focused on a new therapeutic approach to the treatment of arthritis. This approach combines the traditional efficacy of salicylates in arthritis with the advantages of adrenal steroid therapy.¹ With such a combination, the palliative management of the rheumatic diseases may be undertaken in many cases without encountering the side effects and undesirable reactions seen in high dose salicylate or adrenal steroid therapy when used alone. The advent of this combined therapeutic approach has given the physician a new tool in the treatment of the many cases of mild and moderate rheumatic diseases not adequately controlled by salicylates alone.

In this study, we have chosen to use cordex,[®] a product of The Upjohn Company, containing 300 mg. of aspirin and 0.5 mg. of prednisolone per tablet.

SALICYLATES AND ADRENOCORTICAL STEROIDS IN RHEUMATIC DISEASE

Salicylates have been used alone empirically in the treatment of rheumatic fever and gout for over half a century. More recently, they have come to be widely used in the arthritic diseases. Although the efficacy of salicylates in suppressing the acute articular manifestations of rheumatic inflammation is well recognized, the mechanism of this action remains unexplained. Certain experimental studies have suggested a direct anti-inflammatory effect at the cellular level. Other studies have shown an effect of the salicylates on enzymes and on inflammatory and immune processes which may have some relationship to the mechanism of the anti-rheumatic action.²

Studies by Smith et al.,³ Kapp⁴ and many others have shed considerable light on this subject, but a definitive answer is as yet forthcoming. It has been speculated too that some of the benefit from salicylate therapy may be due to pituitary-adrenocortical stimulation. This subject has been reviewed by Hailman.⁵ Salicylates are also known to have a uricosuric effect and have long been used in the treatment of gout.

Delta-1-hydrocortisone (prednisolone) is a derivative of hydrocortisone that differs from the latter in having significantly increased antirheumatic activity with markedly decreased mineralocorticoid activity. An antirheumatic effect may be obtained with prednisolone in a dosage of the order of one-fourth to one-third the required dose

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of hydrocortisone (or about one-fifth the required dose of cortisone).

Spies¹ has shown that combined therapy with salicylates and antirheumatic steroids offers a more practical means than steroids alone for treating many arthritic patients when enough salicylate to produce a strong additive effect is given so that less steroid is required to produce the desired result.

MATERIALS AND METHODS

Our evaluation of this form of therapy is preliminary in nature. The study was of comparatively short duration, and firm conclusions cannot be drawn until six months to one year's experience has been accumulated. Four hundred cases of arthritis were treated with cordex[®] including rheumatoid arthritis, osteoarthritis, gout, and nonspecific types of arthritis. Many of the reported cases were treated for short periods of time, and therapy in all cases was essentially the same. Not all patients obtained full relief of symptoms even on doses considered suppressive for other rheumatic diseases. On the other hand, cordex[®] therapy did induce favorable changes in symptoms in patients who had previously received corticotropin, cortisone, or hydrocortisone.

Table 1 illustrates the types of arthritis treated with cordex[®] in this study. The dosage employed was two tablets four times per day. At this dosage level over 2 grams of aspirin and four milligrams of prednisolone were administered

Submitted February 29, 1956.

per day. It is considered important, particularly in those patients with gouty arthritis, to administer at least 2 grams of salicylates per day to promote uric acid excretion, since it has been shown that small amounts of salicylates may actually bring about uric acid retention. By

TABLE 1. TYPES OF ARTHRITIS TREATED AND DEGREE OF IMPROVEMENT

Diagnosis	Results*	Number of Cases
Rheumatoid Arthritis	xx	200
Without spinal involvement	xx	160
Involving spine	xx	40
Osteoarthritis	xxxx	150
Knees	xxxx	68
Shoulders	xxxx	20
Hips	xxx	20
Elbows	xxxx	14
Spine	xxx	28
Gouty Arthritis	xxx	25
Knees		10
Elbows		2
Toes		6
Wrists		4
Ankles		3
Non-specific Arthritis	xxxx	25
Knees		12
Elbows		7
Wrists		2
Ankles		4

* Grading of results: xxxx, very good, xxx, good; xx, fairly good.

limiting the amount of prednisolone to 4 mg. per day most, if not all, of the usual side effects attributed to adrenal steroid therapy are avoided. Some minor gastrointestinal upsets may occur with this treatment, but these are generally not serious.

RESULTS

The general degree of improvement observed in these patients is shown in table 1. Improvement was judged on the basis of observed improvement in performance in such activities as ability to button coat, comb hair, tie shoe laces, open doors, walk, walk up steps, sit down and arise from chair, turn head right or left, and stoop to touch floor. Mobility of knee joints were tested by heel to buttocks test. In addition, observations were made of finger swelling as noted by the fit of rings and a subjective evaluation of improvement in tenderness and swelling of involved joints. Results were graded on the basis of xxxx, very good; xxx, good; xx, fairly good; and x, poor.

The only reactions noted to this therapy occurred in 25 patients and consisted of mild complaints of slight gastrointestinal upset. With the addition of amphoteric colloids, however, it was possible to continue the medication in all cases. No drug rashes or other reactions were encountered.

SUMMARY AND CONCLUSION

Four hundred cases of various types of arthritis were treated with a combination of prednisolone and aspirin (cortex®) with notable improvement and with a minimum of side effects. While this treatment may not prove suitable for the severe forms of arthritis it is of great value in the mild to moderate arthritic to whom

it may not be desired to give large doses of ACTH or the adrenal corticosteroids alone. It is considered important to give adequate dosage of cortex® so that at least two grams of salicylate per day are administered, although dosage should be adjusted downward to the least amount capable of controlling the symptoms.

ADDENDUM

Since the foregoing work was done, there has been announced a new prednisolone-aspirin combination called cortex® forte. This preparation contains 1.5 mg. of prednisolone and 300 mg. of aspirin, thus tripling the amount of prednisolone available per tablet. Experience with this more potent product will be reported in a forthcoming publication. To date there have been 100 trial cases, and a marked improvement was noted with minimal side effects.

Acknowledgment: We wish to thank the following physicians for their cooperation: Benjamin Lord, M. D., Norwich, Connecticut; Wm. R. Troutwine, M. D., Crown Point, Ind.; S. Hallenbeck, M. D., Millard Tufts, M. D., and Fordyce Ross, M. D., Milwaukee, Wis.

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Chronic Neurodermatitis Deserves Attention

Without entering into a discussion of the physiology of itching, it is known that the motor response to an itching skin is a spinal reflex resulting in rubbing or scratching. Minimal or physiologic itching may be controlled by will power but once the itch-scratch reflex is established it becomes cyclic or appears in waves and is then pathologic. Fatigue, boredom, external irritation, however slight, and emotional crises stimulate the weak impulses into intense paresthesia.

If one examines the predisposing causes, one first must consider the patient and his neurosis. Slow in developing, it may stem from anxiety, fatigue states, overwork, envy, worry (illness in the family), hatred (an alcoholic mate, an overbearing boss). Many cases in the aged are influenced by fixation as a result of an itchy skin, a physiologic manifestation of senility. In about one third of the cases, the dermatitis was secondary to "fixation" in which the sensation of itching persisted after an original minor dermatosis (insect bites, pyoderma) was cured or disappeared. This reaction pattern may be caused by the fear of recurrence or nonacceptance of the original diagnosis.—Norman Tobias, M. D., St. Louis: Missouri Medicine, 53:374, May, 1956.

Interstitial Pneumonia in Infancy and Childhood

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THE child who has a slight cold when put to bed and who expires while asleep proposes a serious problem to all concerned. In the past, many of these deaths were ascribed to suffocation, but more recently, following postmortem examinations, the diagnosis of interstitial pneumonia has been established in many cases.

Very little has been written about the clinical manifestations and treatment of this killer of children. Since there is an apparent increase in the number of cases, at least in this locality, we are presenting several cases which illustrate the problems involved in dealing with this disease.

While a definite diagnosis of interstitial pneumonia can be made only at the autopsy table, its presence should be suspected when the following syndrome presents itself:

This clinical entity usually hits children under the age of four years; however, older children may also be affected. In our series, we have studied some 18 cases, all patients of which were under four years of age. Ten of the patients, whose cases we have studied, expired and eight recovered. Four infants under two months of age were found dead in their cribs and postmortem examinations revealed that the cause of death was interstitial pneumonia, rather than suffocation.

The child who is affected with this disease has usually had a slight cold for several days, but he has not been "sick enough" to see a doctor. He has been playing well, eating well, and has had no temperature elevation. Quite suddenly, the parents note that the child has become ill. He develops a rapid, wheezy respiration and a nonproductive cough. This is the time when most of the patients are brought to the doctor.

When seen by the doctor, the patient is usually afebrile, and the physical examination reveals an almost asthma-like type of breath sounds over both lung fields. The patient usually is using the extra respiratory muscles in an attempt to breathe. It is in this stage of the disease when the recovery rate is the highest and, therefore, vigorous treatment should be started at this time.

If, at this stage of the disease, expectant treatment is resorted to, there follows a rapid downhill course ending in death of the patient. The patient's temperature drops to subnormal and he presents the picture of vasomotor collapse. He is covered with cold sweat, looks extremely

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anxious, and apparently senses some eminent danger. His pulse becomes extremely rapid and later becomes imperceptible. The rapid, rattly respirations continue. Many patients have been digitalized at this stage because it was thought that they were in cardiac failure. Recently, further observations have borne out that this is a stage of vasomotor collapse, and not cardiac failure.

This stage lasts only a few hours and then passes into a stage of rapidly developing hyperthermia of from 106 to 108 degrees F. or higher. The patient usually expires during this stage of the disease. The time elapsed from when the patient is first seen until his death may be less than 12 hours and usually not more than 24.

There are no laboratory aids in the diagnosis of interstitial pneumonia. The white blood counts are variable and the usual report on chest x-rays is "no evidence of any significant disease." In our series of 18 cases, the white blood count has varied from 4,000 to 34,000 and the differential counts have been of no particular significance.

Two of the fatal cases are presented in detail, and one case with recovery is also discussed:

CASE REPORTS

Case 10. A 5 month old white female, was admitted to Toledo Hospital on November 25, 1953, at 12:30 p.m. This child had been seen by a doctor in another town who told her mother that she had a slight cold and gave her some aspirin and nose drops for medication. At 11:30 p.m. on November 24, 1953, she was seen by one of us (D.A.P.) because the mother said she was restless and would not sleep.

Physical examination at that time revealed nothing more than a mild, upper respiratory disease. There was no temperature elevation and the child's chest was clear. She was given a mild sedative and the parents were told to have her checked again the next morning. At 11:00 a.m., she was seen again, and at that time she was in critical condition. Her temperature was 97.4°, and she was in a state of shock. She was covered with a cold sweat and could be roused only with great difficulty. Her respira-

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Submitted March 12, 1956.

tions were rapid, shallow, irregular, and of a grunting nature.

She was rushed to Toledo Hospital, and on admission, her temperature was 103.4° F. She appeared critically ill with rapid and irregular respirations, followed by periods of apnea. There was flaring of the ala nasae and the extra respiratory muscles were being used in respiration. The skin was not cyanotic on admission, however, a moderate degree of dehydration was noted. Her condition was recorded as critical.

Admission laboratory work revealed a carbon dioxide combining power of 22 volumes per cent. Complete blood count showed a hemoglobin of 84 per cent, a red blood count of 3,800,000, and a white blood count of 8,900. The differential count was of essentially normal distribution.

The patient was placed, at once, in a croupette containing alevaire® and oxygen. She was given 1 cc. of dicrysticin® and 100 mgm. of oxytetracycline intramuscularly, at once. The dehydration and acidosis were combatted by giving the patient 250 cc. of Hartmann's solution subcutaneously. In spite of these measures, the patient's condition deteriorated rapidly. Her temperature climbed to 108.2° F., and she expired in four hours.

Postmortem examination revealed bilateral interstitial pneumonia with evidence of an overwhelming, widespread toxic reaction.

Case 9. A 2 month old white male, was admitted to Toledo Hospital on December 9, 1953, at 4:20 p.m. The parents stated that the child had a slight cold for a week prior to admission, but they had not noted any temperature elevation or cough during this period. Four hours prior to admission the patient began, quite suddenly, to experience difficulty in breathing and he refused his feedings. In spite of steam inhalations, the respiratory distress became more marked, and the infant developed grunting respirations.

Physical examination, on admission, revealed a temperature of 98.6° F. and a respiratory rate of 28. The baby was described as a "well-developed and nourished male child." The respirations were grunting, and there was retraction of the costal margins, and the baby was using his extra respiratory muscles in the breathing process. Although the baby appeared acutely ill, no cyanosis could be noted. Examination of the lungs revealed no rales or rhonchi, but there was an increased inspiratory phase of the cycle with the hypernea and grunting respirations previously noted.

Laboratory work, on admission, including a chest x-ray, was all within normal limits.

The baby was placed at once in a croupette with oxygen and alevaire®. He was started on 1 cc. of dicrysticin® intramuscularly, at once. He refused all feedings and his abdomen became rapidly distended. He was given 100 cc. of Hartmann's solution subcutaneously. He became more dyspneic and orthopneic, and finally cyanosis began to appear. At 8:30 p.m., he was given 100 mgm. of oxytetracycline intramuscularly. At 10:00 p.m. his temperature began to rise and by midnight it was 104.2° F. He continued to become less responsive and died at 2:25 a.m., less than 12 hours after his admission.

The postmortem examination revealed an overwhelming bilateral interstitial pneumonia.

Case 12. The patient was a 5½ month old, white, male child, who was admitted to Toledo Hospital on November 20, 1953, at 11:30 a.m. with a history of having had an upper respiratory

TABLE 1. SERIES OF 18 CASES OF INTERSTITIAL PNEUMONIA STUDIED

Case No.	Age	Sex	Date	Where Treated	Outcome	Postmortem Findings
1.	8 mos.	F	1949	Hospital	Expired	I. P. **
2.	5 wks.	M	1949	N. T. *	Expired in crib	I. P.
3.	6 wks.	F	1949	N. T.	Expired in crib	I. P.
4.	5 mos.	F	1949	Hospital	Expired	
5.	4 wks.	M	1950	N. T.	Expired in crib	I. P.
6.	8 wks.	F	1951	N. T.	Expired in crib	I. P.
7.	3 mos.	M	1952	Hospital	Expired	I. P.
8.	3 yrs.	M	1952	Hospital	Recovered	
9.	2 mos.	M	1953	Hospital	Expired	I. P.
10.	5 mos.	F	1953	Hospital	Expired	I. P.
11.	15 mos.	F	1953	Hospital	Recovered	
12.	5 mos.	M	1953	Hospital	Recovered	
13.	18 mos.	F	1953	Hospital	Recovered	
14.	4 yrs.	M	1953	Hospital	Expired	I. P.
15.	2 yrs.	M	1953	Hospital	Recovered	
16.	3 yrs.	M	1954	Hospital	Recovered	
17.	3 yrs.	M	1954	Hospital	Recovered	
18.	2 yrs.	M	1954	Hospital	Recovered	

Note: Cases No. 8 and No. 14 are the same child; Cases No. 15 and No. 17 are the same child

* N T.—Not treated.

** I. P.—Interstitial Pneumonia

infection for the past three days. The parents noted that the child suddenly became listless and could not be interested in food or in playthings. His respirations became labored and grunting. He became cold and clammy and appeared very ill.

On admission to Toledo Hospital, his temperature was 99° F. Pulse rate was 130, and the respiratory rate 26. His skin was cold and clammy and he was obviously in respiratory distress.

He was placed in a croupette containing oxygen and alevaire®. He was started on 5 cc. of oxytetracycline suspension every four hours and 300,000 units of aqueous penicillin intramuscularly every day.

He was moderately dehydrated and was given 100 cc. of Hartmann's solution subcutaneously two times a day. In spite of these measures the shock picture and dehydration increased.

At 3:00 a.m. on November 21, his temperature had reached 106° F. His condition was listed as critical at this time.

500 more cc. of Hartmann's solution was started intravenously by a cutdown in the leg at this time together with chloramphenicol palmitate per gastric tube 5 cc. every six hours. 25 mgm. of acthar® was injected intramuscularly at once and 10 mgm. was given three times a day for the next three days. High daily intakes of intravenous and subcutaneous fluids were maintained for several days.

The patient's condition improved slowly and he recovered sufficiently enough to be discharged on the eighth hospital day.

DISCUSSION

As short a time as six years ago, the treatment of this disease was futile because of the inability to combat the overwhelming toxicity and the vasomotor collapse that accompanies the disease. But now, with the advent of adrenocor-

ticotropic hormones, the treatment of this disease has changed.

As soon as symptoms or findings, suggestive of interstitial pneumonia appear, the problem of proper therapy must be considered at once. This is one instance in which the suspicion of a disease entity is sufficient to institute therapy. As a high index of suspicion is necessary to diagnose this condition, the early and vigorous establishment of therapy is equally necessary in successfully combatting it.

The treatment of interstitial pneumonia can be grouped into two major categories—therapy directed toward the causative organism, and that intended as general supportive measures. Of the two, the latter has been found to be the more essential to recovery.

Since no definite organism has been isolated from a majority of these patients, antibiotic medication is used empirically to prevent secondary invaders. Broad spectrum antibiotics such as chloramphenicol, tetracycline, and oxytetracycline have been preferred, although no one of them has proved more efficacious than the other.

General supportive therapy is by far the more important. The generalized vascular collapse and the frequently violent shock picture must be attended quickly. Intravenous and subcutaneous fluids must be started to correct the dehydration and acid-base imbalances that may be present. M/6 sodium lactate solution usually suffices for correction of acidosis and Hartmann's solution is valuable as a general electrolyte replacer. Whole blood transfusions, in small quantities, have been useful in combatting severe shock. In view of such a vigorous program of fluid and blood administration, one of the earliest procedures is the establishment of a cut-down and permanent intravenous canula.

To further combat the picture of extreme collapse, the early use of adrenocorticotrophic hormones is indicated. Intravenous ACTH and/or hydrocortisone appear to be the drugs of choice. They should be employed in maximum therapeutic amounts. Adequate laboratory facilities to fully determine the effect of these drugs are helpful but not of prime necessity. Hydrocortisone and ACTH should be alternated if therapy is to be continued over a long period of time.

CONCLUSIONS

1. The diagnosis of interstitial pneumonia is difficult to make clinically.

2. When the disease is suspected, therapy must be started at once and must be continued vigorously.

3. The vasomotor collapse part of the disease is the most difficult to treat and its development should be averted, if possible, by early therapy.

4. ACTH and hydrocortisone are the drugs of choice in the treatment of shock if it develops. These drugs might also be used to prevent the development of the shock picture if instituted early in a suspected case.

The Story Behind the Word

Some Interesting Origins of Medical Terms

Ward—This word comes to us from the French word "garder," meaning to keep, and the Italian "guardare," meaning to guard. In Old English the term ward meant "to keep in safety, to watch, or to defend." Hence by extension one of the meanings of this word came to denote a large hospital room, where a number of patients were watched or kept in safety during their illness.

Scrotum—A descriptive term literally meaning the pouch, sac or bag that contains the testicles. Scrotum is the Latin word for a leather pouch, purse or bag, and this term as used anatomically grew out of the ancient Roman habit of applying common descriptive terms to the genitalia or parts thereof.

Womb—This term is derived from the Anglo-Saxon word "wamb" and in Old English meant the belly. It is related to the Icelandic word "vomb," or belly, and the German word "wamme" meaning a dewlap or paunch. Hence the term came to be applied to that part of an animal or human where the young are conceived and nourished until birth.

Wrist—English words that begin with *wr* are of Teutonic origin and most of them convey the sense of twisting. Thus a wreath is a twined garland, and is derived from the Old English word "writh," meaning to twist. The word wry comes directly from the Middle English word "wrien" or twist and hence a "wrist," is that with which we twist our hands.

Idiot—The Greek word "idiotes" signified a man in private life as distinguished from one holding an official position. From this followed the assumption that the public official was a man of higher intelligence and therefore the private citizen was an ignorant person. The term came to be used more and more in a derogatory sense, until it assumed its present restricted meaning of a person of weak intellect.

Rib—A shortening of the Middle English word "ribbe" which came from the Anglo-Saxon word "ribb" which originally meant a beam or strip and is allied to the word "ribbon" in the sense of a narrow band. Hence the word "ribb" came to mean the beams or "ribs" of the chest.

Deltoid—Jean Riolan an early seventeenth century French anatomist named this large muscle of the shoulder the "deltoid" because of its triangular shape. The term "deltoid" is composed of "delta" or the Greek letter "d" which is triangular in shape, plus the Greek suffix "eidos," or like.

Vaseline—This trade-mark name for petroleum jelly was coined by Robert A. Chesebrough in about 1870. Vaseline is a mongrel word and was coined from the German word "wasser," or water, plus the Greek word "elaion," or olive oil.

—HARRY WAIN, M. D., Mansfield, Ohio.

The Use of Frontal Lobe Procaine Injections In the Treatment of Mental Disorder

JAMES M. WHITWORTH, M.D., LAURENCE M. WEINBERGER, M.D.,
MENDEL B. ZIMBLER, M.D., and ALBERT F. PAOLINO, Ph.D.

SINCE the beginning of psychosurgery nearly 20 years ago, a truly formidable number of operations have been devised which testifies to the almost inexhaustible ingenuity of neurological surgeons. The development of psychosurgery came about through the discovery of Egas Moniz, that partial destruction of the frontal lobes produced apparent amelioration of some of the severe sufferings and abnormal behavior of psychotic patients.

In the earlier and more naïve days it was theorized, mainly by Freeman and Watts, that the beneficial effects of lobotomy had to do with specific sectioning of the fronto-thalamic fibers which thereby separated the affective neural mechanisms from the ideational ones. It was quickly discovered however, that overly generous destructions of the frontal white matter resulted in apathetic, shallow, dull patients, and sometimes even in severely demented ones.

In an effort to avoid what came to be called the "frontal lobe syndrome," but at the same time to obtain an improved psychotic patient, better controlled, less extensive or surgically sounder operations were invented. Gyrectomy, topectomy, transorbital leucotomy, cortical thermocoagulation, thermocoagulation of white matter, cingulectomy and cortical undercuttings were some of the methods designed to circumvent the frequently disastrous early and late complications of the standard lobotomy as originally widely recommended by Freeman and Watts.

What gradually has dawned on thoughtful workers and critics is that the beneficial results as well as the complications of frontal lobe surgery bear relation only to the total amount of brain tissue destroyed and not to any particular tracts or fibers sectioned. There is an ever increasing conviction that for practical purposes the frontal lobes may be considered as an equipotential mass of tissue.

Personality and intellectual dilapidations increase as more and more tissue is surgically abstracted from the whole. Freeman already admits to this in 1951 when he writes, "It is coming to be realized that only where there is some personality change is there a satisfactory outcome." And Pool and LeBeau have acknowledged this concept, at least implicitly, when they recommend an excision of 20 to 25 grams of cortex for affective conditions but 35 to 50 grams for dementia praecox!

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It follows, therefore, that since brain tract anatomy is not relevant, any method of graded destruction is suitable. Actually, this is difficult to accomplish by surgical techniques, because of vascular injury, and might better be accomplished by chemical means.

Apparently an intuitive recognition of this idea had led a number of workers, in the past few years, to inject various substances into the frontal lobes. The materials have been such severely destructive ones as alcohol, formalin, or phenol, albeit in very small amounts; others such as blood which causes sterile inflammation and, finally, lowly toxic drugs and anesthetic agents such as procaine in oil, procaine in water, thiodocaine, the methonium drugs, estrogenic hormones and acetylcholine in glucose.*

Procaine solutions, though first suggested in 1939 by Donaggio in Italy, were first used by Putnam in this country in 1950, by Mandl in Austria in 1951, and later by Van Wagenen and Liu, Kropf and Lyonnet, Abeley, Duplay and Cassa and Nulsen and Grant, both to treat psychoses, as well as to predict the probable outcome of surgical methods.

In our small series of 36 patients treated in the Summit County Receiving Hospital we quickly found that 20 to 30 cc. of 0.5 per cent procaine solution injected into each frontal lobe is destructive and produces small areas of cystic necrosis. Whether this is due only to the distending effects of the injection into soft brain tissue or whether there is an additional toxic effect has not been finally decided, but we have strong reasons to favor the mechanical cause. This is based on the observation that when the

*Presented before the Ohio Psychiatric Association in Cincinnati, Ohio, April 20, 1955.

solution is repeatedly barbotaged into the brain, as is generally required, numerous flecks of brain tissue appear in the syringe. Furthermore, Bailey, Small and Ingraham found that procaine could not be chemically detected in cerebral tissue one hour after injection.

Our primary purpose in exploiting this technique is that it appears to accomplish much that surgical methods do, without the hazard of hemorrhage. The injections can be graded in quantity and repeated easily, thereby producing small increments of tissue destruction. The solution can be injected into various parts of the frontal lobe; there is no surgical aftercare and the complications are few and not serious.

We do not believe that psychologic disturbances are cured by producing organic injury and reducing the overall efficiency of the brain, but one can no longer ignore the pragmatic results of psychosurgery in producing worthwhile social gains as well as in relieving many psychotics of their torturing obsessive tensions.

We believe that procaine injections like all other forms of physical treatment are purely treating the symptom and that the mental symptom best relieved is "tension." This has been variously described and defined, but is certainly known to all psychiatrists as self-referred anxiety, torturing self-obsessions, tortured self-concern and the like. Procaïnization fails in varying degrees, like all the others, in the so-called intellectual psychoses.

In summary, we are in a position only to make tentative conclusions since all of our patients have been treated within the past year. About two-thirds have been so benefited that they can work effectively at home or at a job. All of these were patients who had failed to improve from many forms of previous treatment. We have organized an ex-patients' group so that we can follow our results more closely.

We are able to say from our operative and postmortem studies, procaine injections of 20 to 30 cc. in each hemisphere do produce focal necroses in the white matter. However, the detectable organic deteriorations are slight and can be identified only by mild impairment of memory—in no case were there any gross dilapidations of intellect or gutting of personality.

Complaints of Industrial Worker Present Diagnostic Pitfall

In general medicine the patient *asks* the doctor the cause of his illness. In contrast, the worker who assumes his illness is due to the work he does *tells* the doctor the cause. Herein lies a diagnostic pitfall. "*It is bothering me*" or "*That stuff I work with is making me sick*" are common utterances which are too often accepted by physicians who in any other circumstances would not permit their patient to diagnose his case.—Rutherford T. Johnstone, M.D., Los Angeles: *Rocky Mountain M. J.*, 53:451, May, 1956.

KEEPING UP WITH MEDICINE

- HISTAMINE has been found in every organ which has been examined for it; in tumor tissues and in many of the physiologic and pathologic fluids of the body.

* * *

- THERE ARE differences in the content of various tissues and in various species as well as unexplained individual differences in the same species.

* * *

- MAST CELLS are especially rich in histamine and in many instances the total histamine content of an organ can be accounted for in the content of the mast cells.

* * *

- WHEN A SOLUTION containing histamine dihydrochloride (10^6) and a 5 per cent normal human serum previously dialyzed for 24 hours is tested for biological activity with guinea pig ileum, the activity is decreased by about 30 per cent. If serum from an allergic person is used no decrease is observed in the majority of cases.

* * *

- THE ABOVE phenomenon in experimentation is a test of adrenocortical deficiency and in clinical medicine is the first test that has been developed to determine the presence of an allergic constitution. It is called *histaminopexy*.

* * *

- THERE ARE at least three basic ideas about how histamine is released. It may be by leakage through a damaged membrane, by splitting off from a protein or by release from some retaining acid within the cell.

* * *

- IT HAS RECENTLY been shown that many antihistamines produce a bronchoconstrictor action of their own in concentrations between 10^6 and 10^4 . These are the very concentrations which are required to antagonize the anaphylactic reaction of plain muscle and this further detracts from their effectiveness in bronchial asthma.

* * *

- THERE IS a slow reacting substance associated with histamine when certain organs undergo anaphylactic shock. It will contract the bronchioles of the human in concentrations not affecting those of the cat, dog, rabbit or guinea pig. It seems that this substance is of particular importance in human asthma, a condition in which the antihistamine drugs are relatively ineffective.

* * *

- IT WOULD SEEM that, while the participation of "intrinsic histamine cannot be ruled out," "extrinsic" histamine does not play a part in the mechanisms of the vasodilator phenomena.

* * *

- IT IS the concensus of allergists that no one antibiotic should be used constantly but that the physician should have some system of rotating the various antibiotics.—J.F.



A Case Record

From The University Hospital,
Columbus, Ohio

Edited Under the Auspices of the Ohio Society of Pathologists

Philip Wasserman, M. D., President

Presented by H. D. Sirak, M. D., and Emmerich von Haam, M. D.

Edited by Dr. von Haam

PRESENTATION OF CASE

THIS 30 year old white woman gave a history of cyanosis and dyspnea since infancy. In the last few months the dyspnea had so increased in intensity that the patient was forced to sleep on two pillows and became quite dyspneic even when walking slowly. The patient stated that she was able to breathe easiest when in a squatting position. She had had frequent upper respiratory infections.

During the past two years she had had seven phlebotomies, which usually relieved her dyspnea for a short time. Before each phlebotomy her red blood cells numbered 8 to 9 million. The last phlebotomy had been done about a month prior to admission. At the age of 8 the patient lost the vision in her right eye and enucleation was performed when she was 28. The vision in the left eye had diminished to 20/200. She entered the hospital this time again because of marked shortness of breath and cyanosis.

PHYSICAL EXAMINATION

The patient proved to be a well developed, markedly cyanotic white woman appearing chronically ill but not dyspneic in supine position. The pulse was 80 and irregular. The blood pressure in the right arm was 128/76, in the left arm 128/74. Examination of the eyes revealed a right prosthesis. The conjunctivae were markedly cyanotic. The left pupil was distorted in the vertical plane but reacted to light. There was pallor of the left eyeground with marked distortion of the optic disc, which was ill-defined. The neck was full, the trachea in the midline, the neck veins were not distended. There was a 1 cm. discrete nodule in the right lobe of the thyroid. The lungs were clear to auscultation and percussion.

Examination of the heart revealed the point of maximal impulse in the sixth intercostal space in the anterior axillary line, and the heart was markedly enlarged on percussion. A systolic thrill was felt in the third intercostal space to the left of the sternum, and a Grade III systolic murmur was heard over the entire precordium and was transmitted to the left axilla and to the back. The murmur had a blowing quality and was loudest in the third intercostal space to the left of the sternum. A soft diastolic murmur was heard in the third intercostal space to the left of the sternum, and the second pulmonic sound was sharp and louder than the second aortic sound.

Examination of the abdomen gave negative findings. There was extreme clubbing of the fingers and toes, and the nail beds were quite cyanotic. The left thumb was displaced dorsally and quite undeveloped. Radial pulsation was not felt, but the pulsations of the femoral, posterior and dorsalis pedis arteries were quite palpable.

LABORATORY FINDINGS

The admission blood count showed 7,450 white blood cells with 60 per cent neutrophils, 32 per cent lymphocytes, 3 per cent eosinophils, 2 per cent basophils and 3 per cent monocytes; 6.6 million red blood cells and 17 Gm. of hemoglobin. The urine was negative for protein, sugar and acetone, and the sediment showed an occasional white and red blood cell per high power field. The prothrombin time was 80 per cent of normal. Blood cholesterol was 83 mg. with 76 per cent esters; blood urea nitrogen was 17 mg.; total plasma proteins were 7.9 Gm. with 4.2 Gm. albumin and 3.7 Gm. globulin.

The guaiac test for occult blood in the feces was reported as negative. The antistreptolysin titer was 250 units. The test for C-reactive protein was negative. All serologic tests for

Submitted April 20, 1956.

syphilis were negative. The electrocardiogram revealed right ventricular hypertrophy.

ROENTGENOGRAPHIC EXAMINATION

Fluoroscopy of her chest revealed a boot-shaped heart having an increased diameter, a left-sided aorta and diminished vascularity of both lung fields with diminished size of the pulmonary outflow tract. The diaphragm moved well, the trachea was in the midline, and the lung fields contained no lesions. A chest film showed the boot-shaped heart with its apex lifted on the left.

There was a concavity in the left border of the heart generally occupied by the outflow tract of the pulmonary artery which is generally considered typical of a tetralogy of Fallot. In the right anterior oblique diameter a marked enlargement of the right ventricle could be observed. There was also a suggestive enlargement of the left ventricle. The x-ray studies of the chest were reported then as suggestive of a tetralogy of Fallot, but the possibility of cardiac hypertrophy and dilatation of undetermined etiology could not be excluded.

HOSPITAL COURSE

The patient was placed on a strict cardiac regimen, digitalized and placed on absolute bed rest. Following fluoroscopy a cardiac catheterization was carried out, which revealed a high right ventricular pressure with low pulmonary artery pressure. On this basis a tentative diagnosis of tetralogy of Fallot was made and surgery was decided upon.

On the eighth hospital day an anastomosis between the left subclavian artery and the left pulmonary artery was carried out. The patient withstood the procedure quite well. Subsequently, however, she showed only little subjective improvement and continued to be quite cyanotic. Oxygen saturation studies revealed a slight amelioration of the arterial oxygen saturation. Repeated oxygen saturation studies done on the third postoperative day showed again a diminution in oxygen saturation. It was felt that these findings and the lack of any marked postoperative improvement by the patient pointed to the presence of marked pulmonary stenosis.

On the sixth postoperative day the patient suddenly complained of anterior chest pain and became extremely cyanotic. Soon thereafter she became totally unresponsive even to painful stimuli. Oxygen was started and the patient slowly regained consciousness. Her blood pressure stabilized at 140/80. Examination of the chest revealed clear lung field on the right side and dullness over her left chest.

On the seventh postoperative day a reexploration of the previous Blalock procedure was undertaken. The anastomosis appeared to be functioning well, and it was found that pressure

in the pulmonary artery with the shunt occluded dropped to 30 and with the shunt open increased to 50. She was found to have a marked infundibular stenosis rather than a true valvular one. However, it was felt that her condition was too poor to withstand a Brock procedure for correction of the infundibular stenosis.

Postoperatively the patient continued in a semi-responsive state and remained markedly cyanotic even with nasal oxygen. She expired at 3:15 a.m. on the second day following her second operation.

CLINICAL DISCUSSION

DR. H. D. SIRAK: The significant thing about this patient is that she is cyanotic and she is 30 years of age. There is a statement made here, "since infancy." I want to mention that to you because whenever you take a history on a cyanotic patient it is important to find out when he began to get cyanotic, and I don't mean intermittent cyanosis but I mean persistent cyanosis. That is significant because in the differential diagnosis of an adult cyanotic individual by far the most common cardiac cause is a tetralogy of Fallot.

In the group of the 1 or 2-year-olds a whole gamut of cardiac conditions with cyanosis exists, but after the age of 1 or 2 the field narrows down very much to the tetralogy. Very frequently a patient with a tetralogy does not become very cyanotic until after he reaches about a year of age, and many of them are 4 or 5 years of age before they become cyanotic. In addition to a tetralogy of Fallot, an Eisenmenger's complex must be considered, which is essentially the same condition but without the pulmonic stenosis.

In any cyanotic individual you have one thing in common, namely, a right to left shunt. This right to left shunt is caused by an increase in resistance in the pulmonary outflow tract or the pulmonary bed, and for that reason a child with affliction of an Eisenmenger complex may live to early youth before he becomes cyanotic, at which time the great increase in the blood flow through the lungs causes changes in the intima and the media of the pulmonary arteries, thus raising the pulmonary blood pressure. That causes the pressure in the right ventricle to exceed that in the left ventricle and gives you a right to left shunt with the cyanosis. However, this will usually occur at a later age than in a case of tetralogy of Fallot with its pulmonary stenosis.

Another fact which should always be elicited from the history is whether the cyanosis is aggravated by exercise. One is inclined to conclude that cyanosis is always aggravated by exercise. The harder the patient works, the more the tissues need oxygen, so he is always going to be more cyanotic. Well, that is not necessarily true in a young child and the reason for it is this: If the child's cyanosis is due entirely to a mixing of venous and arterial blood, such as occurs in a common truncus or a common ven-

tricle, the cyanosis is more of a constant nature and independent of everyday activity.

A truncus means that there is just one trunk originating from the base of the heart. It has one common valve and receives its blood from both ventricles, which discharge it equally into the truncus. Both blood volumes are mixed in this common mixing chamber and the pulmonary artery and the Botallie duct arise from the ascending aorta as branches. The other condition which produces this mixing of blood is a common ventricle such as a cor trilocular. Arterial and venous blood are mixed in the ventricle and then the mixture is discharged in a more or less homogeneous nature through the pulmonary arteries and the aorta.

A final condition in which patients become cyanotic comparatively late in life is that of a reverse ductus. There is a small group of individuals with a patent ductus arteriosus in whom the blood instead of flowing from the aorta into the pulmonary artery, flows from the pulmonary artery into the aorta, resulting in cyanosis. The reasons for this reversed blood flow are changes in the pulmonary vascular bed with a pulmonary blood pressure which may equal or perhaps exceed that in the aorta. Usually these individuals possess a very large ductus, usually about the same size as the aorta. So you can see that it is very important to ascertain in the history at what age the patient became cyanotic and if his cyanosis became markedly aggravated on exercise.

WELL DEVELOPED?

Under the physical examination it says that the patient was well developed and well nourished. This statement must be incorrect, because there are no cyanotic children who grow up to be well developed and well nourished adults. They will always remain underdeveloped and thin persons.

This patient had an elevated hematocrit. Of course you would expect an elevated hematocrit because you have a peripheral desaturation of oxygen and the body compensates by increasing the red blood cell mass. This condition was treated by repeated phlebotomy. The reason for relief of symptoms after phlebotomy is that with a hematocrit of over 60 per cent the viscosity of the blood rises very abruptly and this makes it much more difficult for the heart to push the blood through the lungs or through a stenosed valve.

Another helpful finding in the differential diagnosis of the cyanosis and the dyspnea of the patient is the electrocardiogram. There is really only one condition which combines cyanosis with left ventricular hypertrophy. That is tricuspid atresia. There the right ventricle is small and underdeveloped and so the electrocardiogram will give you left axis deviation. Of course this patient depends entirely upon a large interatrial septal defect in order to get the blood into the

left ventricle. In all other conditions of early or late cyanosis the right ventricle will be hypertrophied and this of course can be recognized in the electrocardiogram.

Finally, let us say a few words about the x-ray findings. Dr. Manchester mentioned a decreased pulmonary vascularity. In a cyanotic individual a decreased vascularity of the lung fields would most likely point to a tetralogy of Fallot. In an Eisenmenger's complex you would find an increased vascularity because you have more blood going through there over a long period of time until the body finally responds by increasing the resistance in the pulmonary vascular bed.

In summary, then, we have an adult patient with cyanosis since infancy which was aggravated by exercise, and we have an electrocardiogram and x-ray findings to make a diagnosis. We assume then that this is a tetralogy of Fallot. Her cyanosis was accompanied by a dyspnea which was so aggravated by activity that she could not even get out of a chair. Now what are the therapeutic aims we wanted to accomplish? The main thing we wanted to accomplish was to get more blood through the lungs in order to improve the oxygen saturation.

BLALOCK OPERATION

One procedure we have available for this purpose is the Blalock operation. Here the subclavian artery is anastomosed to the pulmonary artery so that some of the blood, which is not too well oxygenated, can flow again through the lungs. The Blalock operation also increases the return of blood to the left ventricle and thus raises the left ventricular pressure. This will help to force some of the blood coming through the septal defect back into the right ventricle and through the pulmonary arteries.

There is another surgical method available called the Potts operation, which consists in a side-to-side anastomosis between the left pulmonary artery and the aorta. It accomplishes the same thing but is more often the method of choice in children, where the subclavian artery is usually too narrow.

What are the indications for surgery in a patient with a tetralogy of Fallot? This depends solely upon the clinical condition of the patient. Some children 5, 10 and even 12 years old, although they can't engage in all the exercises like other youngsters, do quite well and at this stage you would not operate. They still get blood to their lungs by the patent ductus arteriosus, which most of these patients have, and by the bronchial arteries. Only when their body grows will this mechanism become insufficient and they will develop increasing dyspnea with their cyanosis.

The most alarming clinical finding which should cause you to seek surgical help is the appearance of syncope in a cyanotic child. That means seri-

ous anoxia. It is not uncommon that after this symptom appears you may find the child dead in bed. Generally speaking, as soon as patients start squatting in order to sleep and have a marked limitation in their activity the time has come when you have to consider surgery.

There is one other test that can help you decide whether the patient ought to be operated upon. That is catheterization of the heart. In our patient the catheterization of the heart showed a high right ventricular pressure which nearly equalled the left ventricular pressure. Once the catheter passed into the pulmonary artery the pressure fell markedly below normal values. The oxygen concentration of the left ventricle was only slightly below normal but was much below normal in the brachial artery. This suggested a septal defect and an obstruction to the flow of blood into the pulmonary vascular system, in other words, a tetralogy of Fallot.

The difference of about 2.5 volumes per cent of oxygen between the right atrium and the right ventricle tells you that there was some blood coming across from the left side to the right side through her interventricular septum defect. The fact that the oxygen concentration did not change in the pulmonary artery tells us that this patient had no functioning ductus arteriosus. Now peripherally in the left brachial artery the oxygen saturation was way down. This must have been caused by the admixture with right ventricular blood from an overriding aorta plus the oxygen demand of the tissues. These are two very important facts to help you decide whether this patient ought to be operated upon.

PRESSURE DIFFERENCE

From the pressure difference between the right ventricle and the pulmonary artery we know that our patient had a pulmonic stenosis. We also know that the pulmonary artery was getting perfused quite well because this is the normal pressure for the pulmonary artery. The stenosis although severe was being surmounted at the expense of a great strain on the right ventricle, which was sufficient to put a normal pressure into the pulmonary artery.

Another fact to substantiate this is the relatively high oxygen saturation in the left ventricle of 87 per cent. So our patient must have been getting quite a bit of blood through her lungs into the left side of her heart. We must remember, however, that a large percentage of patients with tetralogy of Fallot do not suffer from an inadequate circulation of the blood through their lungs but from the presence of an interventricular septal defect and an overriding aorta. In other words, it is the heart lesion which is giving them the greatest trouble, and this, I believe, was also the case in this patient.

Finally, because of her poor clinical condition the patient was operated upon and the Blalock procedure was carried out. However, after the

anastomosis was accomplished the patient did not improve any, and since she was in a pretty poor condition about 7 days later the clinicians insisted upon reoperation. They went back in and to their great surprise found the shunt was patent. The patient died 2 days later. I do not think we have to speculate much about the cause of death. Any time you operate on a congenital cardiac patient with severe cyanosis and dyspnea and you don't improve his condition, the patient usually will die since you have only added the stress of the operation to his weakened physiology without bringing any relief.

GENERAL CLINICAL DISCUSSION

DR. RYAN: Why do you think that she did not improve after surgery?

DR. SIRAK: Because the primary pathology was the interventricular septal defect and you cannot improve a septal defect by providing a shunt. A shunt is aimed at overcoming a stenosis, but that was not her main pathologic physiological problem.

DR. VON HAAM: Dr. Sirak, I think your most interesting comment was that she must have had a large septal defect. When you say a "large" defect, how large do you estimate it?

DR. SIRAK: The actual size in millimeters is less important than its physiological effect, which I think was considerable. I am convinced that functionally her main problem was not that of a pulmonic stenosis but that her septal defect was the major issue.

CLINICAL DIAGNOSIS

1. Tetralogy of Fallot.
2. Status post Blalock operation and post-operative exploration.

PATHOLOGICAL DIAGNOSIS

1. Tetralogy of Fallot.
2. Status post Blalock procedure and post-operative exploration.
3. Thrombosis of anastomosis of left subclavian artery to left pulmonary artery and of pulmonary artery to right lower lobe.
4. Recent infarction of right lower lobe.

PATHOLOGICAL DISCUSSION

DR. E. VON HAAM: This patient died soon after reexploration and as far as the autopsy is concerned I am going to be very brief, because I would like to leave time for some important discussion afterwards. The body was that of a well developed, thin, and markedly cyanotic young woman showing the recent thoracotomy incision held together by multiple skin sutures. The cervical veins were greatly distended; the fingers and toes showed marked pulmonary osteoarthropathy. The right eye was replaced by a prosthesis, the left eye showed a deformity of the

dilated pupil. All extremities were markedly cyanotic but not edematous. The left pleural cavity and the pericardial sac contained a small amount of clotted blood.

The heart weighed 425 grams and appeared generally enlarged. There was a marked enlargement of the right atrium with distention of the right auricle as well as marked enlargement of the right ventricle, which measured 1.3 cm. in thickness. All other chambers of the heart also appeared slightly dilated and contained the usual postmortem blood clots. There was pronounced dextroposition of the aorta, which was associated with an infundibular stenosis of the pulmonary outflow tract. The stenosed tract measured 0.5 cm. in diameter, while the pulmonic valve measured 5.5 cm. in circumference. The interventricular septum showed a defect in its upper portion measuring 3.5 cm. in diameter. The ductus arteriosus was closed and the aorta and coronary arteries appeared normal.

The lungs appeared heavy and poorly aerated, and the right lower lobe showed a recent infarct measuring 6 cm. in diameter. The lower lobe branch of the right pulmonary artery was occluded by a recent thrombus 4.5 cm. in length which was firmly attached to the wall. The main branch of the left pulmonary artery was occluded by a thrombus measuring 5 cm. in length which seemed to originate at the site of the anastomosis with the left subclavian artery. It appeared more recent than the thrombus of the right lower branch of the pulmonary artery, which may well have preceded the operation. The spleen and liver were enlarged and congested, while the remaining organs did not show any noteworthy changes. Unfortunately we did not have permission to examine the brain.

MICROSCOPIC EXAMINATION

Sections through the thrombus of the left pulmonary artery revealed it to be of very recent origin, in contrast to the thrombus in the right pulmonary vessel, which already showed beginning organization and destruction of the red blood cells. Even older thrombi could be found in some of the smaller branches of the artery, with complete organization and recanalization of some thrombi. Sections through the heart showed marked muscular hypertrophy of the right ventricle with no evidence of degeneration or inflammation. The liver showed marked congestion with central necrosis due to anoxia, and the bone marrow showed markedly increased erythropoiesis, which was the explanation for her polycythemia.

GENERAL DISCUSSION

DR. SIRAK: You did not find any ductus? Sometimes they have a little ductus which is overlooked at surgery.

DR. VON HAAM: We looked very carefully and no patent ductus was found.

DR. DUNSFORD: Would you say that practically all her vessels in the right lung were thrombosed?

DR. VON HAAM: I would not say all vessels but definitely there were many thrombi at various age levels, showing that probably for years she had formed a small thrombus every once in a while and finally a large one in the main lower branch artery.

DR. SIRAK: The presence of thrombi in the smaller pulmonary arteries is not uncommon in this condition and has been reported many times. As a matter of fact, in the reverse ductus arteriosus problem and in the Eisenmenger complex they have been found regularly and put forth as a possible explanation for the pulmonary hypertension.

DR. VON HAAM: Would the polythemia have anything to do with it?

DR. SIRAK: Yes, perhaps it does. Polycythemia certainly accentuates thrombosis and these people are also prone to develop thrombotic occlusion of cerebral vessels. I think it occurs because of the greater viscosity of the blood, but I have never seen thrombosis of a major branch of the artery.

DR. VON HAAM: Do you wish to comment on the recent thrombosis at the site of anastomosis?

DR. SIRAK: At the time of reexploration they felt a definite thrill there and thought that blood was flowing through it. It must have been the trauma of the second exploration. I have never performed a second operation upon a patient with tetralogy.

DR. SCARPELLI: If you anticipate a large interventricular septal defect, why do you go ahead and do your anastomosis? You say that with a large interventricular septal defect you may not have good results?

DR. SIRAK: You always have an interventricular septal defect in a tetralogy of Fallot. There are two lesions to be treated: the pulmonic stenosis and the interventricular septal defect, and functionally this patient was more harmed by the interventricular septal defect for reasons I gave you.

MEDICAL STUDENT: Would an angiogram have been diagnostically helpful in this case?

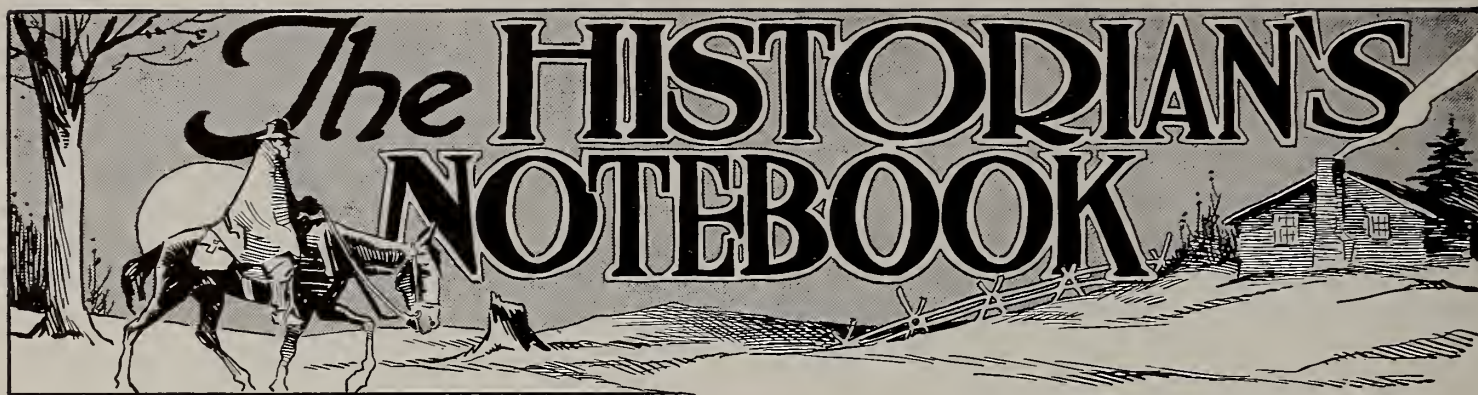
DR. SIRAK: No, you don't need it in such a clear-cut case, and such a procedure in a cyanotic patient does carry some risk.

MEDICAL STUDENT: Is there any reason why these pulmonary thrombi should not have been recognized by the pulmonary x-ray?

DR. SIRAK: An occlusion of the pulmonary artery or its branches does not show up too well when the lungs are well-aerated.

REFERENCES

Taussig, Helen: Congenital Heart Disease. New York, The Commonwealth Fund, 1947.



A Meeting of the Faculty of Starling Medical College In 1858

JONATHAN FORMAN, M. D.

HUMAN nature and conduct vary only slightly through the years. I thought it would interest you to present some of the minutes of the earlier meetings of the Faculty of Starling Medical College:

"Columbus, Ohio, 19th April, 1858.

"The Faculty of Starling Medical College met, pursuant to adjournment. Dr. Smith,* the Dean being absent, on motion by Dr. Carter, Dr. Dawson was chosen Dean pro-tem.

"On motion by Dr. Wormley, Dr. Loring was chosen Secretary pro-tem.

"On motion by Dr. Carter, seconded by Dr. Loring, Dr. Wormley was appointed a Committee to draft resolutions and by-laws for the government of the Faculty. This committee was ordered to report at the next meeting, if possible.

"On motion by Dr. Carter, seconded by Dr. Wormley, a special meeting of the Faculty was called for Saturday evening, May 1st.

"The suggestions of this special meeting are: the hearing of the report of the Dean appointing a delegate or delegates to the National Medical Convention at Washington City, and the election of officers for the present year.

"There being no further business, on motion by Dr. Wormley, the Faculty adjourned, to meet at the office of Dr. Smith on Saturday evening, May 1st, at 8 o'clock.

"S. LORING, Secretary."

* * *

"Columbus, Ohio, May 1, 1858.

"The Faculty of Starling Medical College met pursuant to adjournment.

"All the members of the Faculty were present at the appointed time. The Dean then read his annual report, which was unanimously accepted.

"The Committee on by-laws and regulations

then made a report which was accepted and ordered to be recorded among the minutes of the Secretary. The by-laws and regulations reported by said Committee are as follows:

"1. The officers of the Faculty of Starling Medical College shall be: a Dean and a Secretary, who shall be elected by ballot annually at the first regular meeting in March following the closing of the Winter course of lectures.

"2. It shall be the duty of the Dean to preside at all meetings of the Faculty; to receive and disburse all monies belonging to the same, of which he shall keep an account open to the inspection of the Faculty at all times, and at the expiration of his term of office he shall present to the Faculty a full statement of all monies received and paid out during said term of office, which shall be submitted to a Committee of two, who shall audit the account before the following meeting.

"3. It shall be the duty of the Secretary to notify the members of all meetings of the Faculty, and to keep a regular account of all their proceedings, which shall be reported at the following regular meeting.

"4. There shall be a regular stated meeting of the Faculty every alternate Saturday evening. An extra or special meeting may be called by the Dean or two members of the Faculty at any time.

"It was moved by Dr. Carter, as an amendment to the by-laws of the Faculty, that a collector be appointed, whose duties shall be to collect all notes and accounts received by the Faculty from students and others and placed in his hands by the Dean for that purpose."

(NOTE: At this time there was a great rivalry between the schools at Cleveland, Cincinnati, and Columbus. *The Ohio Medical and Surgical Journal* and the Faculty of the Starling Medical College had been quite vocal in their condemnation of the extension of credit to prospective medical students by the two rivals, and, in a holier-than-thou attitude, had denied that any such program was going on in Columbus. The

*This is Doctor Stephen Smith of the College of Medicine Faculty, whose statue is now being transferred from in front of old St. Francis Hospital to a place on the University Campus. This statue will be remembered by the older citizens of Columbus as having stood at the corner of Broad and High Streets until automobile traffic forced its removal.

appointment of a collector, and other evidence in the meetings of the Faculty, indicate, however, that they were just as active in this rivalry as were the other schools.)

"On motion by Dr. Loring, it was unanimously agreed that Dr. Wormley be appointed collector and that he enter immediately upon the duties of his office.

"It was moved by Dr. Wormley and seconded by Dr. Carter that the Faculty proceed to the election of a Dean and Secretary for the present year.

"On the *first* ballot, it was ascertained that Dr. Dawson had rec'd. 3 votes, Dr. Wormley had two votes, and Dr. Smith one vote; no election.

"On the *second* ballot it was ascertained that Dr. Dawson had received 2 votes, Dr. Smith 2 votes, and Dr. Wormley 2 votes;—no election.

"On the *third* ballot it was ascertained that Dr. Dawson received 3 votes, Dr. Smith one vote, and Dr. Wormley, 2 votes;—no election.

"On the *fourth* ballot, Dr. Dawson received two votes, Dr. Smith one vote, and Dr. Wormley three votes;—no election.

"On the *fifth* ballot Dr. Dawson rec'd three votes, Dr. Smith one vote, and Dr. Wormley 2 votes;—no election.

"On the *sixth* ballot, Dr. Dawson rec'd two votes, Dr. Smith two votes, Dr. Wormley two votes; still no election.

"It seeming likely that no election could be made by the balloting under the rule, it was unanimously agreed to suspend the rule and decide the election by plurality vote. Dr. Smith then obtained leave to withdraw his name from the list of candidates. A vote was then cast, and Dr. Dawson having received four votes, was declared duly elected the Dean, and was conducted to the Chair by Dr. Smith, the former Dean.

"The Faculty then proceeded to elect a Secy.:

"On the *first* ballot, Dr. Loring having rec'd a majority of all votes cast, was declared duly elected Sec'y.

"It was moved by Dr. Wormley and seconded by Dr. Hamilton that the Dean make a report to the next regular meeting of the Faculty on the financial affairs of the college, including the period from 1854 to the present date.

"On motion by Dr. Smith, Dr. Dawson was appointed delegate to the National Medical Convention at Washington City.

"On motion by Dr. Loring, the Dean was directed to confer with some proper person concerning the delivery of the next annual address. After various suggestions on the subject, the Dean was directed to confer with Messrs. C. N. Olds, Rev. J. D. Smith, and Wm. Anson Smythe, and if possible to get one or the other to deliver said address.

"On motion by Dr. Wormley it was agreed that the next meeting be at the office of Dr. Dawson. There being no further business to transact, on motion by Dr. Wormley, the Faculty adjourned,

to meet on Saturday evening, May 15, at the office of Dr. Dawson.

"s/ S. LOVING, *Sec'y.*"

Franklin County Pelvic Cancer Delay Committee Report

By JOHN H. HOLZAEPFEL, M. D.
Columbus, Ohio, Chairman

The Franklin County Pelvic Cancer Delay Committee met at 12 o'clock noon on April 18, 1956, at the Columbus Health Center. Two cases were presented.

Case 21: A 47 year old white female in 1942 had an ectopic pregnancy. Both tubes were removed. In April, 1950, she noticed spotting. As her mother had carcinoma, she saw her family physician who, without doing a pelvic examination, told her not to worry. She was seen again by her physician, and again no pelvic examination was done. She was placed on hormones. In January, 1951, she was seen by another physician, who, when bleeding recurred, referred her to another physician. He did a subtotal hysterectomy without a pelvic examination. Report revealed squamous cell carcinoma.

The patient was then referred to clinic. At that time she had a small stump. It was felt that she would not be a candidate for cobalt. Received nylon threads, 5500 R. followed by cobalt. When last seen she had hematuria and examination revealed a change in the bladder mucosa. Specimen was taken for biopsy and pathologist's report was squamous carcinoma of the bladder. Bladder area was treated with nylon threads. Histopathologic examination of larger biopsy specimen revealed radiation change; no carcinoma. On examination April 17, 1956, she was doing well. Para cervical area was free. Six months without any bladder symptoms. Papanicolaou smear and repeated biopsies were negative.

Comments: DR. JOHN C. ULLERY: Patient delay of three months and physician delay of one year.

DR. FRED HAPKE: Why subtotal hysterectomy instead of total hysterectomy?

DR. WILLIAM E. CRISP: Pelvic examination should have been done on initial visit.

Case 22: A white female, age 26, was seen December 20, 1955, with complaint of vaginal spotting. Past history was negative. Following dilation and curettage in June, 1955, patient was told tissue was "all right." Examination in December revealed uterus slightly enlarged. Cervix cyanotic. It was thought the patient was pregnant; spontaneous abortion on January 16. Spotting still persisted and on cervical biopsy report was epithelioma of the cervix, Grade II. A total hysterectomy and bilateral salpingo-oophorectomy were done, and diagnosis was pre-invasive carcinoma of the cervix.

Comments: DR. ULLERY: Treatment for carcinoma in situ was fine. Because of quick diagnosis, it was found.

DR. CRISP: Should treatment be done on the basis of an initial diagnosis?

DR. HAPKE: If first diagnosis was correct, then treatment given should not have been done.

The question came up as to what future therapy might be indicated in this case.

Comment: DR. JAMES WILLIAMS: Why not do an extraperitoneal node dissection in place of external therapy?

Proceedings of The Council . . .

Important Policy Matters Decided in Action on Committee Reports; Changes in Workmen's Compensation Medical Fee Schedule Suggested

A REGULAR meeting of The Council of the Ohio State Medical Association was held on Saturday evening, June 2, and Sunday, June 3. All members of The Council were present except Dr. C. T. Atkinson, Middletown, Councilor of the First District. Others attending were: Dr. Jonathan Forman, Editor of *The Journal*; Dr. H. P. Worstell, Chairman of the Committee on Industrial Health and Workmen's Compensation; and Messrs. Nelson, Saville, Page and Moore.

Dr. Meiling, the President, reported to The Council on committee appointments and, by official action, such appointments were confirmed. (See Page 686 this issue.)

LETTERS OF APPRECIATION

Dr. Meiling read a copy of a resolution, adopted by the Woman's Auxiliary to the Ohio State Medical Association at its 1956 Annual Meeting, expressing appreciation to the officers, Advisory Committee and Executive Staff of the Ohio State Medical Association for their help and assistance during the past year.

Also, Dr. Meiling read a communication from Mr. P. C. Bechtel, Chairman of the State Planning Committee for Health Education in Ohio, thanking the Ohio State Medical Association for its active support of the Third Ohio Conference on Physicians and Schools held recently at Lake Hope.

By official action, the minutes of the meetings of The Council held on March 11, 1956, and on April 9 and April 12, 1956, Cleveland, were approved.

MEMBERSHIP STATISTICS

Membership statistics were reported as follows by the Executive Secretary: OSMA members as of June 1, 1956, 8,478; compared to a total of 8,633 as of December 31, 1955. Number of OSMA members affiliated with the AMA as of June 1, 1956, 7,489, compared to a total of 7,512 who were AMA members in 1955.

1957 ANNUAL MEETING

The Council then held a lengthy discussion regarding the 1956 Annual Meeting and, on the basis of this discussion, made a number of recommendations regarding the 1957 Annual Meeting, May 14, 15, 16, Columbus, for consideration by the Committee on Scientific Work.

The following suggestions regarding the program for 1957 were made: Consideration should be given to "live clinics"; more general sessions; fewer section meetings; and discussions on economic, social, legislative and legal aspects of medicine. It was agreed that a larger room for

meetings of the House of Delegates should be secured and that alternate delegates should be invited to attend the sessions of the House of Delegates.

Ways and means of expediting the handling of a large number of resolutions were discussed. Dr. Meiling suggested that perhaps multiple reference committees could be appointed to handle the resolutions. The Council agreed that this might be a solution to the problem and recommended that this idea be put into effect next year.

A suggestion that a new section be created, to be known as the Section on Industrial Medicine, was referred to the Committee on Scientific Work for consideration.

The Council recommended that in 1957 the House of Delegates meet for dinner and the first business session on Monday, May 13, the day prior to the opening of the scientific program, in order to give more time for consideration of official business. The Council also recommended that the dinner given by The Council, honoring past-presidents and committee chairmen, be scheduled for Tuesday night, May 14.

In order to provide more continuity and experience for the handling of all details in connection with the Scientific and Educational Exhibit, The Council, by official action, recommended that the chairman of the Committee on Scientific Work, after consultation with the President, appoint a Committee on Scientific and Educational Exhibits to consist of five physicians, each to serve a term of five years, except that initial appointments should be made for terms of one, two, three, four and five years.

It was announced that the dates and places for future annual meetings have been decided upon as follows: 1958, April 15, 16, 17, Cincinnati; 1959, April 21, 22, 23, Columbus; 1960, May 17, 18, 19, Cleveland.

Mr. Page presented a report on meetings and actions of the Committee on Maternal Health. The report, by official action, was approved. (See article on Page 747.)

WANT PRESCRIBED COURSE DEFINED

The Council adopted a motion recommending that the Committee on Education confer with the State Medical Board, the Ohio Society of Anesthesiologists and with the chairman of the Committee on Maternal Health for the purpose of defining what would be recognized by the State Medical Board as "a prescribed course in anesthesia," as stated in Section 4731.35 of the Revised Code and applying to registered nurses. It was pointed out that the purpose of this would

be to provide a guide for hospitals which might desire to set up a training course in anesthesia for nurses.

MATERNITY HOSPITAL REGULATIONS

The Council then considered proposed revisions in the regulations of the Ohio Department of Health governing the licensure of maternity departments of hospitals, promulgated by the department under the authority of Section 3701.34 of the Revised Code. The proposed new regulations will be considered at a public hearing to be held by the Ohio Public Health Council at 10:00 a. m., Saturday, June 23, 1956, Hearing Room No. 2, State Office Building, Columbus.

After extensive consideration of the various proposals The Council instructed the Executive Secretary to send to the Public Health Council recommended changes agreed upon by The Council, and requested Dr. Meiling, the President, to appear at the public hearing to present testimony regarding the Council's recommendations.

HOSPITAL COMMITTEE REPORT

Dr. Woodhouse presented a report on behalf of the Committee on Hospital Relations with regard to a meeting of that committee held on May 13 at the Neil House, Columbus. The report of the committee was approved by official action. (See story on Page 744.)

PUBLIC RELATIONS COMMITTEE REPORT

Mr. Saville presented a report on behalf of the Committee on Public Relations and Economics. All sections of the report were discussed at length. A slight amendment in the proposed wording of paragraph four of Substitute Resolution P was agreed to. By official action, The Council then approved and adopted the report of the committee. (See Page 742 for story on this committee report.)

ECONOMIC EDUCATION WORKSHOP

Dr. Martin and Dr. Monger were designated by The Council to officially represent the Association at the opening session of the Workshop on Economic Education at Ohio University, Athens. The Association is one of the organizations sponsoring this project for teachers throughout the state.

WORKMEN'S COMPENSATION

Dr. Worstell presented a report for the Committee on Industrial Health and Workmen's Compensation, recommending certain changes in the Workmen's Compensation Medical Fee Schedule.

After discussing all items in the report carefully, The Council approved and adopted the report and instructed the Executive Secretary to transmit the recommendations contained in the report to the administrator of the Bureau of Workmen's Compensation and the Industrial Commission. (See story on Page 746.)

ETHICAL QUESTIONS

A report from the Judicial and Professional Relations Committee was presented by the Executive Secretary on behalf of that committee. After a thorough discussion of the report, The Council, by official action, approved and adopted the report.

RE MENTAL HYGIENE REPORTS

The report covered the following matters:

A request from the Ohio Psychiatric Clinic Directors Association as to whether or not it is a violation of professional confidence for a director of a clinic to report the name and diagnosis of a patient to the State Division of Mental Hygiene as required by the division was considered. Information studied by the committee revealed that the law requires that all data identifying patients submitted by local clinics to the State Department of Mental Hygiene and Correction must be regarded as confidential information. Analysis of the various sections of the Revised Code of Ohio, specifically Sections 5123.11, 5119.01, 5123.04, 5119.27 and 339.65, revealed that mental hygiene clinics receiving financial aid in whole or in part from the state, must report such information as may be required by the Department of Mental Hygiene and Correction.

Therefore, the committee expressed the opinion that since the reporting of information appearing in the files of such a local clinic to the state department is required by law, such reporting does not constitute a violation of the Principles of Medical Ethics.

WHAT IS A "HOSPITAL"

Another question given careful study by the committee was one submitted by the Cincinnati Academy of Medicine as to whether certain establishments in that city which are advertising in the telephone directory as an "Emergency Hospital" can legally and properly call themselves a "hospital."

The committee was advised by Mr. Wayne Stichter, legal counsel of the Association, that the state department of health on two occasions has defined the term "hospital." One definition has been issued by the director of health pursuant to the provisions of Sec. 3701.07 relating to annual hospital registration. The second definition appears as a part of Regulations 400-415 issued by the department pursuant to the provisions of Sec. 3701.73, providing for the establishing of minimum standards for certain hospitals in Ohio.

It was pointed out that although Sec. 3701.07 states that every hospital shall annually register with the state department of health, there is no penalty for failure to do so. Nevertheless, if an establishment wishes to be registered as a hospital it must qualify under the definition promulgated by the director of health.

Mr. Stichter advised the committee that in his

opinion it is quite probable that only establishments desiring to qualify to receive Social Security funds are required to meet the provisions of Sec. 3701.73 and Regulations 400-415, including the definition of the term "hospital" found in Regulation 400-G.

However, he pointed out that despite weaknesses in the enforcement and penalty provisions of the two sections of the law referred to, it remains that two official definitions of the term "hospital" have been promulgated and that either or both of these definitions might properly be employed as a guide in judging whether or not an establishment may properly call itself a "hospital."

RECOMMENDATION OF COMMITTEE

After a careful analysis of the data before it and of the interpretations presented by Mr. Stichter, the committee adopted the following opinion:

1. Any establishment in Ohio calling itself a "hospital" should meet at least one of the two definitions of "hospital" as promulgated by the State Department of Health.

2. Evidence available to, and reviewed by, the committee leads the committee to believe that establishments in Cincinnati calling themselves "emergency hospitals" do not comply with the terms of either definition.

3. Use of the prefix "emergency," or any other prefix, does not in itself exempt an establishment from meeting the requirements of one of the health department's definitions.

RELATIONS WITH ATTORNEYS

A draft made by Mr. Stichter of a proposed local code of relationship between a local medical society and a local bar association which could be offered by the OSMA as a "model" or guide to local medical societies desiring to consider this matter was analyzed by the committee. Certain changes were suggested. Mr. Stichter was asked to revise the draft for submission to the committee at a later date for action.

OLD AGE PENSION MEDICAL PROGRAM

A brief report on behalf of the special committee, which had been appointed by Dr. Meiling to serve in an advisory capacity to the Division of Aid for the Aged, to assist in setting up a new medical program, effective July 1, was presented by the Executive Secretary. The committee has had one meeting and is planning another meeting in the near future. The work of the committee is to make suggestions regarding a fee schedule and regarding rules and regulations governing the medical program. Because of the time element involved, The Council, by official action, authorized the committee to make its recommendations directly to the division prior to July 1.

MALPRACTICE INSURANCE

The Council then considered that part of the

report of the Reference Committee on Resolutions at this year's Annual Meeting, which referred to a resolution on the possibility of group malpractice insurance for members of the Association and which had been transmitted to The Council for study. By official action, The Council referred this question to the Committee on Public Relations and Economics for investigation. It was pointed out in the discussion that the Legal Department of the American Medical Association is at this time engaged in a comprehensive nationwide study of the malpractice insurance problem and that the results are being made available to the state medical societies from time to time.

The Executive Secretary advised The Council that only eight county medical societies have submitted reports for the first quarter of the year on malpractice suits, threats of suits or settlements in each county, and that apparently the method used by the Association to secure such data is not proving practical. The Council advised that this plan should be continued for one more quarter and that a report should be submitted at the September meeting of The Council.

LEGISLATIVE CONFERENCES IN FALL

It was decided to hold the customary district legislative conferences this coming Fall at which the qualifications of candidates and legislative issues will be discussed. The Executive Secretary was authorized to send out the usual questionnaires to secure information about the candidates and to arrange for the district conferences in September and early October.

REQUEST FOR AID TABLED

A communication asking the Association to provide financial assistance for the family of a recently deceased physician was read and thoroughly discussed. The Council expressed sympathy and deep interest in the problem but decided that it would be unwise to use general funds of the Association for a project of this kind, as it would set a precedent and might create future problems which would be very difficult to cope with. Several members of The Council pointed out that at some future time the establishment of an earmarked fund to meet such contingencies might be considered. Others stated that in their opinion these problems should be met by the local societies.

LETTER OF THANKS FROM NFIP

A communication from the National Foundation for Infantile Paralysis, thanking the Ohio State Medical Association for its active assistance and cooperation during the 1955 polio vaccine demonstration program and subsequent programs sponsored by the Foundation, was read and ordered filed.

PRESENT AD POLICY APPROVED

In considering an inquiry as to whether *The Ohio State Medical Journal* would accept adver-

tising from a firm merchandising brandy, The Council, by official action, decided that the present policy against advertising of alcoholic beverages in *The Ohio State Medical Journal* should be continued.

CANCER INVESTIGATING PLAN

A suggestion from the American Medical Association that each state medical society establish a Cancer Commission, one responsibility of which would be to collect and evaluate scientific and clinical evidence on claims for the diagnosis and treatment of cancer, was considered. By official action, The Council designated the Committee on Cancer of the Ohio State Medical Association to handle such responsibilities until such time as there would be some reason to feel that a different setup should be established.

UMW CONFERENCE REPORT

Dr. Hopkins discussed a report which he had prepared and submitted to members of The Council in advance of the meeting on the recent United Mine Workers Conference held at Charleston, West Virginia, under the sponsorship of the AMA. Dr. Hopkins attended the conference as the official representative of the Ohio State Medical Association. In discussing the report Dr. Hopkins referred to the action of the Committee on Public Relations and Economics on this subject, which report had been considered at this meeting of The Council and approved. It was Dr. Hopkins' opinion that there must be close liaison between the Ohio State Medical Association and the United Mine Workers Welfare and Retirement Fund in order that the problems which are constantly arising between the fund and physicians can be handled in a practical manner.

OMI SCHEDULE

A communication from the Cincinnati Society of Internal Medicine, relating to some of the indemnities and procedures of Ohio Medical Indemnity, was discussed. The Council was advised that a special committee of OMI was meeting this day with representatives of the Cincinnati Society of Internal Medicine in Cincinnati to discuss these questions. The Council, therefore, by official action, postponed further consideration of the letter from the Cincinnati Society of Internal Medicine pending a report on the outcome of the conference between representatives of that society and OMI.

DEPENDENT MEDICAL CARE PROGRAM

Copies of an explanation of the law enacted by Congress recently on the matter of medical care for dependents of members of the Armed Forces were distributed to members of The Council. The Council was advised that there was no reason for immediate action by The Council but that members should be well informed about this law as it may be necessary for The Council

in the not too distant future to take some action on what kind of plan shall be set up in Ohio under which dependents of members of the armed services would be provided with medical care at government expense.

PHYSICIANS AND SCHOOLS

Mr. Page made a verbal report regarding the recent Third Ohio Conference on Physicians and Schools at Lake Hope on May 8-10. He pointed out that the Finance Committee had reported a balance of around \$363.00 and would like the approval of the contributing organizations, which includes the OSMA, to retain this fund for the promotion of future conferences and for certain local follow-up conferences. By official action, The Council approved this request and in the same action expressed its appreciation to Mr. Page for the work which he has been doing in helping to make these conferences of physicians and schools so successful.

AMA RESOLUTIONS

Consideration was given to several requests that the Association again sponsor a resolution in the House of Delegates of the AMA, requesting the AMA to rescind its previous action restricting supervision of the use of radium or radioactive isotopes to certified radiologists. This resolution was introduced a year ago but was not adopted. Following a discussion, The Council authorized the reintroduction of the resolution at the coming June meeting of the AMA and requested Dr. Carl A. Lincke, an AMA delegate, to introduce the resolution.

Dr. Meiling read to The Council a letter which he had received from Dr. John C. Ullery, Chairman of the Department of Obstetrics and Gynecology, Ohio State University. The letter referred to a resolution which will be introduced at the June meeting of the AMA advocating that straight internships in obstetrics and gynecology be continued until such time as all straight internships in all medical specialties are simultaneously abolished. By official action, The Council recommended to the Ohio delegates that they support this resolution at the June meeting of the AMA.

REPORTS BY COUNCILORS

Reports on activities in their districts were then submitted by members of The Council. During this period it was announced that a Ninth District meeting is being planned for October 18 at Ironton; and that the date of October 24 has been set for the Sixth District meeting at Youngstown.

There being no further business, The Council adjourned.

Attest: CHARLES S. NELSON,
Executive Secretary.

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Tetracycline Lederle

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The prevention and control of cellulitis, abscess formation, and generalized sepsis has become commonplace technique in surgery since ACHROMYCIN has been available. Leading investigators have documented such findings in the literature.

For example, Albertson and Trout¹ have reported successful results with tetracycline (ACHROMYCIN) in diverticulitis, gangrene of the gall bladder, tubo-ovarian abscess, and retropharyngeal abscess. Prigot and his associates² used tetracycline in successfully treating patients with subcutaneous abscesses, cellulitis, carbuncles, infected lacerations, and other conditions.

As a prophylactic and as a therapeutic, ACHROMYCIN has shown its great worth to surgeons, as well as to internists, obstetricians, and physicians in every branch of medicine. This modern antibiotic offers rapid diffusion and penetration, quick development of effective blood levels, prompt control over a wide range of organisms, minimal side effects. There are 21 dosage forms to suit every need, every patient, including

ACHROMYCIN SF

ACHROMYCIN with STRESS FORMULA VITAMINS. Broad-range antibiotic action to fight infection; important vitamins to help speed normal recovery. In *dry-filled, sealed capsules* for rapid and complete absorption, elimination of aftertaste.



¹Albertson, H.A. and Trout, H. H., Jr.: *Antibiotics Annual* 1954-55, Medical Encyclopedia, Inc., New York, N.Y., 1955, pp. 599-602.

²Prigot, A.; Whitaker, J. C.; Shidlovsky, B. A., and Marmell, M.: *ibid*, pp. 603-607.



LEDERLE LABORATORIES DIVISION

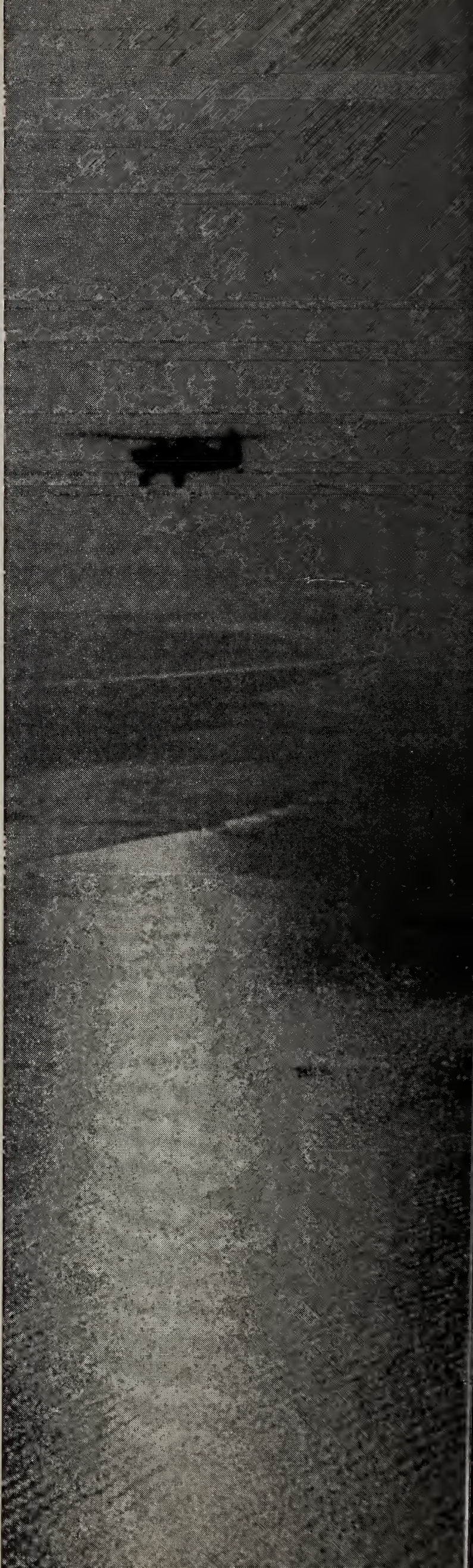
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Economic and Legislative Issues . . .

Committee Considers UMW Medical Problems; Amends Policy Regarding Such Funds; Advocates Law to Make More Dogs Available for Teaching

AT a meeting of the Committee on Public Relations and Economics of the Ohio State Medical Association on Sunday, May 20, action was taken on the following questions and problems, among items considered:

Drafting of an addition to Substitute Resolution P as adopted by the House of Delegates at the 1956 Annual Meeting, relating to relationships between physicians and insurance and welfare funds, as directed by the House of Delegates.

Consideration of problems which exist between physicians in Belmont County and the United Mine Workers Welfare and Retirement Fund.

Adoption of a recommendation for a standardized form to be used by Ohio physicians, if they desire, in making reports to insurance companies. (See page 749 for special story on insurance forms.)

Need for legislation to make it possible for medical and research institutions in Ohio to secure an adequate number of dogs for teaching and research purposes.

Action and recommendations of the committee on these matters were officially approved by The Council at its meeting on June 3. (See pages 736 - 739 for Council action.)

The meeting of the committee was attended by the following: Dr. Herbert B. Wright, Cleveland, Chairman; Dr. Frederick P. Osgood, Toledo; Dr. Horace B. Davidson, Columbus; Dr. John A. Fraser, East Liverpool; Dr. John H. Budd, Cleveland; Dr. R. L. Meiling, Columbus, President; Dr. Charles L. Hudson, Cleveland, Past-President; Dr. Robert S. Martin, Zanesville, President-Elect; Dr. Robert E. Hopkins, Coshocton, Seventh District Councilor; Dr. H. T. Pease, Wadsworth, 11th District Councilor; Dr. B. C. Diefenbach, Martins Ferry; Dr. Bertha Joseph, Martins Ferry; Dr. Peter Lancione, Bellaire; Dr. Leo D. Covert, Bellaire; Attorney Burt Joseph, representing the Belmont County Medical Society; Dr. Thomas D. Kinney, Cleveland; Dr. A. C. Corcoran, Cleveland; Mr. M. John Hanni, Executive Secretary, representing the Cleveland Academy of Medicine; and Secretaries Nelson, Saville and Page of the State Headquarters Office.

UMWA PROBLEMS

Dr. Robert E. Hopkins, Coshocton, Councilor for the Seventh District, opened the discussion of the medical care program of the United Mine Workers of America Welfare and Retirement

Fund. Supplementing his comprehensive report which had been referred to the committee by The Council, Dr. Hopkins presented a memorandum on the Fourth Conference on Medical Care in the Bituminous Coal Mine Area sponsored by the Committee on Medical Care for Industrial Workers of the American Medical Association, held at Charleston, West Virginia, May 6, which he attended as the official representative of the Ohio State Medical Association. Dr. Hopkins stated that the picture has not changed much and the problems remain the same as they were when he made his original report on the situation in Belmont County.

Drs. Diefenbach, Lancione, Covert and Joseph explained some of the problems and misunderstandings which exist in Belmont County between physicians of the county and the UMWA-WRF. There was a general discussion of the quality of medical care being rendered to miners; financial arrangements; policies of the UMWA-WRF and its rules and regulations, etc.

ACTIONS TAKEN

After a lengthy discussion, the committee took the following official action:

Commended Dr. Hopkins for his diligence and good judgment in delving into the UMWA-WRF situation in Belmont County, and for his excellent report, most of the conclusions of which were embodied in Substitute Resolution P passed by the House of Delegates April 12, at Cleveland, and are now the official policy of the Ohio State Medical Association.

Suggested that representatives of the Pittsburgh Area Office of the UMWA-WRF be invited to meet with the Committee on Public Relations and Economics for a preliminary discussion to explore the possibility of the negotiation of a written agreement between the Ohio State Medical Association and the UMWA-WRF to govern the medical service of UMWA-WRF in Ohio.

Recommended an addition to Substitute Resolution P which had been adopted by the House of Delegates in April and referred to the committee for further study. The complete resolution as revised, (new matter underscored) reads as follows:

SUBSTITUTE RESOLUTION P

WHEREAS, Organized medicine wishes to retain its rightful place in American medical practice and to continue a system which has given the country its preeminent position in the medical world by taking a firm stand early on

matters which encroach upon the rights, privileges and obligations of its members.

THEREFORE, BE IT RESOLVED, That the House of Delegates of the Ohio State Medical Association go on record as opposing:

1. Gradually increasing restrictions on the acceptability of general practitioners for payment of fees from insurance or welfare funds.

2. The issuance of over-all directives that seemingly condemn and often handicap all physicians because of the alleged misdeeds of a few.

3. The use of economic or other types of pressure by any fund, insurance company or other agency to force patients to accept the services of any particular physician.

4. Action by any agency qualifying or disqualifying a physician by standards other than merit and competence as judged by his colleagues, or certification by specialty boards or membership in professional societies.

5. The use of economic pressure or coercion by local unions or any other agencies in attempting to secure hospital staff membership for physicians unacceptable to the hospital staff involved.

DOG LEGISLATION

Drs. Kinney and Corcoran, representing the Cleveland Academy of Medicine, explained the need in Ohio of legislation to make dogs more readily available for medical research. They explained that approximately 5,000 dogs are needed yearly in Cleveland for teaching and research purpose; that about 20,000 dogs are destroyed yearly by the Animal Protective League of Cuyahoga County; that no dogs are available from the County Dog Pound; that very few are available from the City Pound because of the withdrawal of operating funds. They expressed the belief that a similar problem exists in other medical centers in the state. Both pointed out that the present system of acquiring dogs is too uncertain and expensive and does not meet the need of the medical schools and hospitals for an uninterrupted flow of dogs for research purposes. Passage of a State Dog Pound Law, similar to that in effect in six other states, is imperative, they said.

INTRODUCTION OF BILL APPROVED

After careful consideration, the committee adopted the following motion:

"It is recommended that inasmuch as there appears to be a need for legislation which would make it possible for reputable and bonafide medical and research institutions and organizations in Ohio to secure an adequate number of dogs and other animals for teaching and other purposes, the Ohio State Medical Association should prepare and sponsor proper legislation in the 1957 session of the Ohio General Assembly.

"It is further recommended that the President

appoint a special committee composed of representatives of the Ohio State Medical Association and other interested groups to undertake the promotion of the proposed legislation."

President Meiling announced that Dr. Wright had tendered his resignation from the committee because of the pressure of other responsibilities. In reluctantly accepting the resignation, Dr. Meiling thanked Dr. Wright for his 8 years of faithful service on the committee. Dr. John H. Budd of Cleveland was named to fill Dr. Wright's unexpired term, until 1958. Dr. Meiling also named Dr. Mayfield as chairman of the committee for the year 1956-1957.

Policy Statement Explains Who Is Considered Registered Technician

Ohio physicians will be interested in the following statement issued by the American College of Radiology:

"It has come to the attention of the American College of Radiology that an organization in Enid, Okla., has recently corresponded with technicians regarding membership in the 'American Radiography Technologists.'

"When and if applicants are admitted to membership, the mailed information from the Enid headquarters states this recognition authorizes the applicant to use the title 'RT' after his name.

"For this reason, the American College of Radiology is releasing the following statement for the information and guidance of the medical profession in the United States, x-ray technicians, hospital personnel, and other interested persons:

"The American Registry of X-Ray Technicians, the headquarters of which is in Minneapolis, Minn., and whose Executive Secretary is Mr. Alfred B. Greene, R.T., is the sole organization offering certification or registration of x-ray technicians recognized by the American College of Radiology and the American Medical Association.

"The American Registry of X-Ray Technicians offers an opportunity for examination after the technician has followed a course of training approved by the American Medical Association, the American College of Radiology and the American Society of X-Ray Technicians.

"These examinations are conducted by members of the American Registry of X-Ray Technicians. Upon successful completion of examination the technician is registered and is authorized to place after his or her name the designation, R.T., Registered Technician.

"It is the considered opinion of the American College of Radiology that the designation, R.T., has in the eyes of the medical profession, x-ray technicians, hospital personnel and the public, acquired a well defined meaning signifying: the successful under-taking of a given course of training, a specific level of achievement, in x-ray technique, adherence to a well defined code of conduct, and passage of a supervised examination.

"The College would lament and discourage the action of any organization or individual: offering registration of x-ray technicians merely upon application rather than examination; beclouding the meaning of 'R.T., Registered Technician,' by attributing to the initials some other meaning such as 'radiological technician'; and misleading those concerned with competence in x-ray technique by sponsoring registration outside the purview of recognized medical and x-ray technician organizations."

Hospital Accreditation . . .

Special Meeting of Committee on Hospital Relations Held To Hear Criticisms and Recommendations; Resolutions Drafted

A SPECIAL meeting of the Committee on Hospital Relations was held in the Neil House, Columbus, Sunday, May 13. Members of the committee present were: Dr. George A. Woodhouse, Chairman; Dr. Robert S. Martin, Dr. Paul F. Orr, Dr. Charles L. Hudson, Past-President; and Dr. Richard L. Meiling, the President.

Pursuant to an invitation to the presidents of the state's 88 county medical societies to send representatives to the meeting to express their recommendations, criticisms, suggestions, etc., concerning the program being carried on by the Joint Commission on Hospital Accreditation, the following were in attendance representing 12 county societies:

THOSE IN ATTENDANCE

Ashtabula—Dr. Harry K. Lynne; Columbiana—Dr. J. Keith Rugh; Cuyahoga—Dr. C. R. Jablonoski and Dr. C. L. Leedham; Franklin—Dr. James J. Hughes and Mr. William Webb, Assistant Executive Secretary of the Columbus Academy of Medicine; Hamilton—Dr. Ralph G. Carothers, Dr. J. Robert Hudson, Dr. Joseph H. Jones, Dr. R. D. Mansfield, Dr. D. C. Rivers, Dr. Clyde S. Roof, Dr. C. A. Sebastian, Dr. S. A. Trufant, Dr. Earl C. Van Horn and Mr. Edward F. Willenborg, Executive Secretary of the Cincinnati Academy of Medicine; Medina—Dr. John L. Jones and Dr. H. T. Pease; Montgomery—Dr. L. O. Frederick, Dr. Zelda E. Heiney and Dr. F. L. Shively, Jr.; Muskingum—Dr. G. T. Thompson; Ottawa—Dr. A. D. Miessner; Putnam—Dr. Will W. Moody; Summit—Dr. Robert J. Burkhard and Dr. H. E. Muller; Williams—Dr. J. W. Greene.

Dr. Jay B. Price, Cleveland, represented the Ohio Academy of General Practice.

Also present were: Dr. Paul A. Davis, Akron; Dr. C. C. Sherburne, Columbus; and Dr. L. Howard Schriver, delegates to the American Medical Association; and Dr. Kenneth B. Babcock, Director of the Joint Commission on Accreditation of Hospitals (by invitation).

PURPOSE OF MEETING

Dr. Woodhouse explained that the meeting had been called in accordance with the following action taken by the House of Delegates at Cleveland, April 12, 1956:

"Resolution B on problems involved in the accreditation of hospitals needs more study than time will permit at this meeting, in the opinion of your committee.

"Therefore, we recommend that the resolution be referred to the Committee on Hospital Relations of the Association; that the committee be directed to hold hearings on this question in the immediate future; that all county medical societies be invited to send representatives to such hearings; and that the committee prepare a report which can be considered by Ohio's A. M. A. delegates as the basis for a resolution to be presented to the House of Delegates of the American Medical Association at the June, 1956, A. M. A. meeting in Chicago."

ORIGINAL RESOLUTION EXPLAINED

Dr. Sebastian, President of the Cincinnati Academy of Medicine, gave the background for the introduction of Resolution B. He said that it was a composite of recommendations received from various specialty groups, including the Cincinnati Surgical Society, the Society of Internal Medicine, the Southwestern Ohio Society of General Physicians and others. Other members of the Cincinnati delegation and representatives of other societies expressed their views on accreditation and queried Dr. Babcock concerning the procedures and administration of the Joint Commission.

POINTS RAISED

Testimony included objection to the 75 per cent attendance requirement at staff meetings; domination of medical staff by hospital administrators; unnecessarily increased paper work; Joint Commission should restrict its accreditation to administrative affairs and not judge professional matters; arbitrary directions and procedures are leading to an increase in hospital costs without a commensurate increase in the quality of hospital or professional benefits to patients; review of internship and residency training should be a function of the American Medical Association Council on Medical Education and not the Joint Commission; requirements are burdensome on small hospitals, etc.

DR. BABCOCK'S COMMENTS

During the discussion, Dr. Babcock stated that 172 Ohio hospitals have been surveyed by the Joint Commission. Of those, 144 have been fully approved, 7 have been provisionally approved, and 21 non-approved. Of those 21, 11 are mental institutions which have been non-approved on recommendation of the American Psychiatric Association.

Dr. Babcock said that the Joint Commission

is interested in the quality of care of patients. He explained that the standards now in effect are basically those of the American College of Surgeons of 35 years ago with a few changes worked out with certain groups. Dr. Babcock emphasized that all questions of policy and the final action on a surveyor's hospital report are determined by the Joint Commission, which consists of 20 members, of whom 16 are physicians—13 of them clinicians. He believes that surveying for hospital accreditation should be separated from surveying done by the A. M. A. for approval of intern and residency training. He also explained why, for legal reasons, the functions of the Joint Commission cannot be undertaken solely by the A. M. A.

Dr. Babcock said that much of the misunderstanding concerning the Joint Commission is due to its lack of ability to communicate to physicians its true purpose—improvement of the quality of care. He felt that there is little disagreement with the purpose, that the "gripes" come mostly from the mechanics involved. Dr. Babcock urged physicians to write to the Joint Commission and to the groups represented on the Commission, expressing their opinions and suggestions concerning the Commission and its procedures and regulations.

RESOLUTION DRAFTED

The committee reviewed the testimony which had been presented, and discussed it fully. It drafted the following resolution for submission to The Council for official action and recommended that it be presented at the June meeting of the AMA House of Delegates. (See page 737 for Council action approving the resolution and recommendation.)

"WHEREAS, the objective of the Joint Commission on Accreditation of Hospitals is to enable physicians and hospitals to aid each other in the delivery of the best possible medical care to patients, and

"WHEREAS, certain regulations enacted by the Joint Commission on Accreditation of Hospitals and their interpretation by representatives of the Joint Commission make it unnecessarily difficult to achieve the above objective, and

"WHEREAS, there is reason to believe that certain unnecessary requirements are leading to an increase in hospital costs without a commensurate increase in the quality of professional and hospital care of patients; now therefore be it

"RESOLVED, that the House of Delegates of the American Medical Association recommends:

"1. That the Joint Commission on Accreditation of Hospitals revise its standards in order to provide more discretion locally for medical staffs and hospital authorities to make appropriate adjustment of their organization activities to fit the hospital's particular needs and those of the community;

"2. That hospital staffs be permitted to determine for themselves how often they need to

hold staff meetings and what kind of meeting is best suited to solve the problems of the individual hospital;

"3. That accreditation never be withdrawn by the Joint Commission from a hospital in which questionable standards prevail, until after a period of three to six months has expired and an opportunity has been given to the hospital to raise its standards within the period specified;

"4. That the Joint Commission of Accreditation of Hospitals and the Council on Medical Education and Hospitals of the American Medical Association shall maintain close liaison to assure that hospitals with teaching programs for interns and residents shall be continuously advised as to the rules and regulations of both agencies in order to avoid a situation whereby a hospital with a satisfactory training program might lose its accreditation;

"5. That the American Medical Association, other interested national groups, and state and county medical societies be urged to more adequately publicize the activities of the Joint Commission on Accreditation of Hospitals so that the medical profession and hospital authorities will have a better understanding of the Commission's purposes, policies, regulations and their interpretation."

New Buildings Being Added to Ohio's Mental Institutions

Five new living area buildings are being opened this spring at Ohio mental hospitals, it was announced by Dr. John D. Porterfield, director of the Department of Mental Hygiene and Correction.

The new buildings, which add 625 beds to the rated capacity of the state's mental institutions, are all one-story structures of fireproof construction. Each cost \$225,000.

Two are located at Orient State Institute for the mentally retarded, in southwestern Franklin County. The others are at Longview State Hospital, Cincinnati; Columbus State School for the mentally retarded, and Tiffin State Hospital.

"These new buildings will help somewhat to alleviate the overcrowding in our mental hygiene program," Dr. Porterfield said. "Further relief will be afforded by the department's 1956 building program which calls for construction of mental hospital facilities with a rated capacity of 2145 beds.

"Architects are now engaged in drawing plans for all but one of these facilities. Two of the projects will be built with funds appropriated by the last session of the General Assembly, while the 11 others will be built with funds from the \$150 million bond issue approved by the voters of Ohio last November.

"These projects are in addition to the treatment and service facility projects included in the department's mental hygiene building program."

Request W.C. Fee Increases . . .

Recommendations for Changes in Workmen's Compensation Fee Schedule
Drafted by Committee; Approved by Council; Submitted to the Bureau

THE House of Delegates at the 1956 Annual Meeting adopted a resolution directing the Committee on Industrial Health and Workmen's Compensation to submit to the Bureau of Workmen's Compensation recommendations for increases in certain areas of the Workmen's Compensation Medical and Surgical Fee Schedule.

The committee has drafted certain recommendations. They were approved by The Council on June 3 and have been transmitted to the Bureau of Workmen's Compensation and members of the Ohio Industrial Commission. Following are the recommendations officially presented on behalf of the OSMA:

MAXILLARY BONE

The fee for open reduction operation on the maxillary bone should be consistent throughout the fee schedule and a fee of \$150.00 under both the ear, nose and throat procedures schedule and under the fracture schedule should be allowed.

GENITOURINARY PROCEDURES

*Catheter, insertion and replacement of on home visit (in addition to regular treatment fee and including cost of catheter)\$ 10.00

LABORATORY PROCEDURES

*Fungus, culture for (in addition to regular treatment fee)\$ 5.00

NEUROSURGICAL PROCEDURES

Lobotomy, transorbital\$100.00
Lobotomy, prefrontal 200.00

OPHTHALMOLOGICAL PROCEDURES

Foreign body, removal of (embedded or multiple)\$ 15.00
Glaucoma, operation for 175.00
Extraocular muscles, primary operation on:
One muscle\$100.00
More than one muscle 150.00

SURGICAL (ORTHOPEDIC)

Arthrogram, injection of contrast for (exclusive of roentographic study)\$ 25.00
Coccyx, removal of 75.00

SURGICAL PROCEDURES

Saphenous vein ligation and complete stripping:
Unilateral\$150.00
Bilateral 200.00
Pneumonectomy 300.00
Lobectomy 300.00
Splenectomy 200.00

MISCELLANEOUS

*Proctoscopy and/or sigmoidoscopy (in addition to the regular treatment fee).....\$ 10.00
First treatment at office (day) 7.00
First treatment at home or hospital (day) 8.00
First treatment at office, home or hospital (night emergency between 8:00 P.M. and 7:00 A.M. and any time on Sundays and legal holidays) 10.00
Subsequent treatment at office, including ordinary medication and dressings 4.00
Subsequent treatment at home, including ordinary medication and dressings 5.00
Subsequent treatment at hospital 4.00
Mileage beyond corporation limits, per mile one way 60
*Tetanus antitoxin (prophylactic) in addition to the regular treatment fee. This item should carry an asterisk 3.00
*Gas bacillus and tetanus antitoxin combined (prophylactic) in addition to the regular treatment fee. This item should carry an asterisk 4.00
*Superficial x-ray therapy 5.00
Should be in addition to the regular treatment fee and should be denoted as such by an asterisk.

Under the ophthalmological procedures schedule the item *corneal scar, treatment of, by beta-radium, \$5.00 should be in addition to the regular treatment fee and should be so denoted with an asterisk.

Three Ohio Grants Awarded by Life Insurance Research Fund

The Life Insurance Medical Research Fund has announced that it has awarded \$960,340 in grants and fellowships to aid research on heart disease this year, three of the awards being to Ohio institutions.

The new awards bring to \$8,161,170 the total of the Fund's contributions to heart work since its organization in 1945. This year's allocations will aid 58 heart research programs and support 22 fellowships for studies in 49 institutions.

The grants in Ohio include the following:

Cleveland Clinic Foundation, for research by Dr. W. J. Kolff, with a new disposable artificial kidney, \$9,900.

Western Reserve University School of Medicine, for research by Dr. A. B. Stavitsky on antibody formation in relation to the immune and hypersensitive state, \$15,400.

Western Reserve University School of Medicine, for research by Dr. Harland G. Wood on the biosynthesis of precursors of cholesterol, \$19,800.

Anesthesia by Nurses in Obstetrics . . .

Statement of Policy From Maternal Health Committee Approved By Council; Opinion on Who Should Use Obstetrical Beds Expressed

TWO policy matters of importance, one involving administration of anesthesia by nurses in obstetrical cases and the other as to whether or not beds on the maternity floor of a hospital should be used for other than obstetrical patients, were among items of business transacted by the Committee on Maternal Health of the Ohio State Medical Association on Sunday, May 27.

Actions and recommendations of the committee on May 27 were reported to The Council on June 2 and approved by The Council, therefore becoming official policies of the Association. (See Council Minutes, page 736).

For some time the committee had had under advisement the question of anesthesia in obstetrical cases. In some hospitals anesthesia has been administered in obstetrical cases by nurses without special training in anesthesia and in some instances not in the immediate presence of a licensed physician.

PRESENT LAW CITED

Section 4731.35 of the Revised Code of Ohio (a part of the Medical Practice Act) provides that a registered nurse may administer an anesthetic providing she does so "under the direction of and in the immediate presence of a licensed physician" and further provided she "has taken a prescribed course in anesthesia at a hospital in good standing."

Conflicting views arose between certain hospitals and their obstetrical staff and the Ohio Department of Health. The latter which is charged with inspection of and enforcement of the law licensing maternity hospitals and maternity departments of hospitals insisted that the law setting forth under what conditions a nurse can or cannot administer an anesthetic should be complied with in order to insure the safety of patients.

Eventually, the question was submitted to the Ohio State Medical Association for adjudication. The Council requested the Committee on Maternal Health to study the matter and submit a report.

TEXT OF OFFICIAL STATEMENT

Following is the statement drafted and submitted by the committee to The Council on June 2 and officially adopted by The Council as the policy of the Association:

"The committee reports to The Council that it has reviewed the statute 4731.35 with regard to the administration of anesthesia by nurses, which reads as follows:

"Sections 4731.01 to 4731.47 inclusive, of the

Revised Code shall not apply to or prohibit in any way the administration of an anaesthetic by a registered nurse under the direction of and in the immediate presence of a licensed physician, provided such nurse has taken a prescribed course in anaesthesia, at a hospital in good standing."

"The committee has held conferences with physicians in different fields of practice and has investigated the laws and practices in other states.

"Furthermore, the committee has investigated anesthesia deaths as reported in the literature, in which all types of anesthetics are implicated in these deaths.

"And, as the complexities of anesthetic agents are increasing daily, requiring considerable knowledge of the use of these agents, the committee approves of the intent of the statute.

"The committee feels that local difficulties can be solved by educational efforts on the part of the medical profession.

"In this connection, the committee has initiated an educational program in anesthesia for physicians and nurses in close cooperation with the departments of anesthesia of the several medical schools and postgraduate courses are currently available."

WANT PRESCRIBED COURSE DEFINED

After adopting this statement of policy, The Council requested the Committee on Education to confer with the State Medical Board, the Ohio Society of Anesthesiologists and the chairman of the Committee on Maternal Health for the purpose of defining what would be recognized by the board as a "prescribed course in anesthesia" as applying to registered nurses, the purpose of which would be to provide a guide for hospitals which might desire to set up a training course in anesthesia for nurses.

ADMISSIONS TO MATERNITY FLOOR

A statement of policy on what type of patient should be admitted to the maternity floor of a hospital also was submitted to The Council by the committee and adopted by The Council. The question arose when the staff of an Ohio hospital requested the OMA to ask the Ohio Department of Health to revise its regulations governing maternity hospitals so as to permit use of obstetrical beds for certain types of "general" patients in order to give the hospital more beds for other than obstetrical patients. The statement of policy on this reads as follows:

"The regulations covering this subject as now written in the Ohio Sanitary Code, and as proposed

in New Regulation 78, A, of the proposed revision of Regulations 71 to 93, inclusive, of such code, answer the question to the satisfaction of the committee.

"The proposed regulation reads as follows:

TEXT OF NEW PROPOSED RULE

"A. (Segregation of patients.)

"1. To secure segregation of maternity patients and newborn infants from other types of patients, a maternity hospital operated as a part, unit, or division of a general hospital must form a separate unit of the institution.

"2. In addition to maternity patients in the third trimester of pregnancy, patients in the first and second trimester of pregnancy who develop complications due to pregnancy may be admitted to a maternity hospital subject to the administrative policies of the board.

"3. No patient with a communicable disease or a septic condition, or being suspected of having a communicable disease or septic condition, shall be admitted to a maternity hospital.

"4. Maternity patients, not having or not being suspected of having a communicable disease or septic condition, delivered outside the maternity hospital, may be admitted to an isolation room within the maternity hospital or to a single rooming-in unit."

"The committee feels that on the maternity floor, only patients who are directly connected with the pregnant state should be admitted.

"In the best interests of both mothers and their babies, other patients, including gynecological (non-pregnant), should not be admitted."

MISCELLANEOUS ACTIONS

The committee also transacted the following miscellaneous business:

Requested the committee chairman, Dr. A. J. Ruppertsberg, to represent the committee at the public hearing on June 23 on the proposed new regulations of the Ohio Department of Health relating to maternity hospitals.

Instructed the chairman to begin the preparation of maternal death cases for publication under committee sponsorship in *The Ohio State Medical Journal*. It was decided that the following suggestions concerning the technical details merit consideration in the preparation of the reports:

1. A standing lead should be written to point out the purpose and objectives of the Committee on Maternal Health of the Association.
2. A terse synopsis of the number of cases reviewed to date should be presented statistically with each report.
3. The chairman to develop an appropriate piece of art work to accompany the standing head.
4. That the reports themselves should be

pitched to the clinical pathological conference type of report.

5. Comments from a variety of consultants should be secured for use in connection with the report.
6. In choosing reports, it was suggested that examples which typify a class of cases be selected.

Reviewed additional maternal mortality reports from the various counties.

American College of Physicians Announces PG Courses

The American College of Physicians has announced a series of postgraduate courses to be held at various institutions beginning in the Fall. Additional information may be obtained from the College at 4200 Pine Street, Philadelphia 4, Pa. The courses are as follows:

Recent Advances in Cardiovascular Disease, Mt. Sinai Hospital, New York, October 8-12.

Clinical Neurology, Jefferson Medical College of Philadelphia, October 15-19.

Internal Medicine, Vanderbilt University, Nashville, October 15-19.

Recent Advances in Internal Medicine, University of Washington, Seattle, October 22-26.

Selected Problems in Internal Medicine, University of Oklahoma, Oklahoma City, November 26-30.

Gastroenterology, University of Pennsylvania, Philadelphia, December 3-7.

Electrocardiography, University of Utah, Salt Lake City, December 3-8.

Pathologic Physiology of the Blood Dyscrasias, Washington University, St. Louis, Mo., February 18-22, 1957.

The 38th Annual Session of the College will be held April 8-12, 1957, in Boston.

New Members of O. S. M. A.

The following are the names of the new members of the Ohio State Medical Association since May 1, 1956. The list shows the county in which they are affiliated, city in which they are practicing, or temporary address in cases where physicians are taking postgraduate work.

CLINTON COUNTY

Wilhelm A. Kraeling,
Clarksville

CUYAHOGA COUNTY

Domenico Fragomeni,
Cleveland

FRANKLIN COUNTY

John R. Thompson,
Columbus

HAMILTON COUNTY

Christine Mary Carter,
Cincinnati
Gerald W. Grawey,
Cincinnati
Mary Margaret Martin,
Cincinnati

LORAIN COUNTY

Antanas Savicinas,
Wellington

MAHONING COUNTY

David B. Brown,
Youngstown
George H. Davies, Sebring

MONTGOMERY COUNTY

Mahmud T. Faruki, Dayton

RICHLAND COUNTY

Oscar W. Klein,
Mansfield
James L. Secrest,
Mansfield

Standardized Insurance Report Form For Use by Ohio Physicians Is Drafted by OSMA Committee; Approved by Council; Effective Jan. 1

ACTION of The Council, June 2-3, approving a simplified standardized insurance report form for Ohio physicians, who desire to use it, may be the answer, in at least one field, to the irritating problem of "unnecessary paper work" which appears to plague most practicing physicians.

After many months of study, the Committee on Public Relations and Economics reached the conclusion that the series of forms agreed upon by the Health Insurance Council and the American Medical Association did not solve the problem. It was felt that the six forms were too many and that they included many unnecessary questions.

Forms developed by county medical societies in Cincinnati, Canton, Cleveland and elsewhere were reviewed. It was reported that the Cincinnati form is being accepted in that area by most insurance companies in lieu of their own forms. The U. S. Railroad Retirement Board has approved acceptance of the Cincinnati simplified form in lieu of the Board's own form to accompany an application for sickness benefits under the Railroad Unemployment Insurance Act.

The Committee decided that the Cincinnati form, with a slight addition, is adequate for recording pertinent information in a particular claim as known by the attending physician.

The Council set January 1, 1957, as the date when the form would be made available to members of the Association who desire to use it, and directed that representatives of The Health Insurance Council and the American Medical Association be given an opportunity to comment on the proposed form prior to that date.

Akron Surgical Society Acts On Unethical Practices

According to the January-February, 1956, American College of Surgeons Bulletin, 23 members of the Akron Surgical Society have subscribed to the following resolution adopted by that society:

WHEREAS, There has recently been much publicity about unethical and questionable surgical practice, to wit, 1) Unnecessary surgery, 2) undertaking surgical procedures without adequate training, 3) fee-splitting, and 4) ghost surgery; and

WHEREAS, The American Medical Association and the American College of Surgeons have both been outspoken in the condemnation of these evils and have emphasized that "the essential of ethical financial relations in the medical profession is simple honesty," and

WHEREAS, The Akron Surgical Society is willing to assume its responsibilities as a leader in surgical thought and conduct in this community; now, therefore, be it

Resolved, That the Akron Surgical Society, individually and collectively, reaffirm its adherence to the principles of medical ethics of the American Medical Association; be it

Further resolved, That this Society endorse and support the stand taken by the American Medical Association and the American College of Surgeons in regard to surgical evils mentioned above; be it

Further resolved, That this Society invite the

Board of Regents of the American College of Surgeons, or their designate, to audit the books of any member of this Society whose signature appears hereon—as proof positive that they are not engaging in unethical financial relations; be it

Further resolved, That this resolution be incorporated in the minutes of the Akron Surgical Society, and that copies be sent to the Summit County Medical Society, and the American College of Surgeons, to be recorded with these organizations.

Council on Medical Physics Established by AMA

The Board of Trustees of the American Medical Association has announced the establishment of a Council on Medical Physics to carry on activities in the field of apparatus, instruments and devices. The action was taken when the Board adopted a recommendation from its Committee on Scientific Councils.

This new Council, which replaces the former Council on Physical Medicine and Rehabilitation, will be composed of 13 individuals selected from various fields of medicine, chosen because of the special knowledge that they have but not as representatives of specialties.

New Military Dependent Medical Law . . .

Defense Department Now Drafting Regulations To Make New Program Effective: Too Early To Know How Plan Will Be Carried on in Ohio

THE Defense Department is engaged in the drafting of regulations to carry out the provisions of the law recently enacted by the Congress, setting up a new medical and hospital care program for the dependents of military personnel.

The task will take weeks and perhaps months. The main problem facing the Department of Defense is that of choosing a workable method of contracting for private medical and hospital care. There are several possibilities: Blue Cross, Blue Shield, arrangements with state medical societies, commercial insurance or home town care with the government paying according to fee schedules. The regulations of the Defense Department will spell out in detail how the new program will be handled.

The Council of the Ohio State Medical Association has discussed this question on several occasions—as recently as June 3. However, no plans on how the new program will or should be carried on in Ohio can be considered until the Defense Department regulations and ideas are promulgated.

COST AND ELIGIBILITY

Here is a detailed analysis of the provisions of the new law (H. R. 9429) prepared by the Washington Office of the American Medical Association:

The new plan makes medical care a statutory right, defines dependents, and provides uniform benefits for Army, Navy, Air Force, Marine Corps, Coast Guard, and Commissioned Corps of Coast and Geodetic Survey and U. S. Public Health Service. This protection for dependents is designed to make military careers more attractive and thus help to reduce personnel turnover.

All dependents may be treated in military facilities "subject to availability of space, facilities, and capabilities of staff," with the medical officer in charge making the conclusive determination as to whether the particular facility is able to handle the particular dependent.

Only spouses and children of active duty personnel are eligible for medical care from private physicians and in private facilities "under such insurance, medical service or health plan or plans" as the Secretary of Defense may contract for, after consulting Secretary of Health, Education, and Welfare.

Freedom of choice for spouses and children between military and private facilities is restricted by the following provision: The Secretary of Defense may limit or prohibit the use of private

facilities in any area where in his opinion military facilities are adequate to care for the service families.

Other beneficiaries, all restricted to care in military facilities on a "space available" basis, include parents and parents-in-law residing in the home of the service member and for whom he pays at least half the support, retired members and dependents and dependents of persons who died while on active duty or retired. Limitation: Regardless of age, non-career retired reserves with less than eight years' active service and dependents not eligible.

Charges to dependents: While in military facilities, dependents will pay subsistence and in-hospital charges (currently totaling \$1.75 per day); as a restraint on excessive demands, "uniform, minimal" charges may be made for outpatient care in military facilities. In private facilities, the charges will be at the same rate or the first \$25, whichever is the larger. All other medical care costs will be met by the federal government, through absorption of charges in military facilities and payment for insurance or other costs in private facilities. The Bureau of the Budget has approved \$76 million to meet the first year's costs of private care; no estimate has been announced of the cost of the program in military facilities. The Secretary of Defense will establish the subsistence and in-hospital charges, described in the bill as "fair charges."

Administration: Secretary of Defense to administer for Army, Navy, Air Force, and Marine Corps and Coast Guard when it is a part of the Navy; Secretary of Health, Education, and Welfare to administer for Coast and Geodetic Survey and Public Health Service, and the Coast Guard when not a part of the Navy. In writing regulations, etc., except those applying only to the military, the Secretary of Defense required to consult the Secretary of Health, Education, and Welfare. Secretary of Defense authorized to set up advisory committees on insurance, medical service, and health plans.

CARE IN MILITARY FACILITY

Military medical facilities will provide: 1. Diagnosis, treatment of acute medical and surgical conditions, treatment of "contagious diseases," immunization and maternity and infant care. 2. Hospitalization for nervous and mental disorders, chronic diseases or elective medical and surgical treatments but only in "special and unusual cases" and for not more than 12 months.

This would be provided at the discretion of the Secretary of Defense.

PRIVATE CARE PROGRAM

The private care program will provide: 1. Hospitalization in semiprivate accommodations up to one year for each admission, including all necessary services and supplies furnished by hospital. 2. Medical and surgical care incident to hospitalization. 3. Complete obstetrical and maternity service, including prenatal and postnatal care. 4. Physician or surgeon's services prior to and following hospitalization for bodily injury or surgery. 5. Diagnostic tests and procedures, including laboratory and x-ray examinations accomplished or recommended by the physician incident to hospitalization.

Also included under private care may be surgery in a physician's office, x-rays or laboratory tests outside the hospitals, but not "what is normally conceived to be outpatient care." "Reasonable" limitations, additions, exclusions and definitions could be authorized by the Secretary of Defense. Scope of private care may not exceed that furnished in military facilities. If hospitalization is required beyond one year, patients may be transferred to military facilities, or the federal government will assume cost in private facility.

DEFINITION OF MILITARY DEPENDENTS

"The term 'dependent' means any person who bears to a member or retired member of a uniformed service, or to a person who died while a member or retired member of a uniformed service, any of the following relationships:

"(a) The lawful wife;

"(b) The unremarried widow;

"(c) The lawful husband, if he is in fact dependent on the member or retired member for over one-half of his support;

"(d) The unremarried widower, if he was in fact dependent upon the member or retired member at the time of her death for over one-half of his support because of a mental or physical incapacity;

"(e) An unmarried legitimate child (including an adopted child or stepchild), if such child has not passed his twenty-first birthday;

"(f) A parent or parent-in-law, if the said parent or parent-in-law is, or was at the time of the member's or retired member's death, in fact dependent on the said member or retired member for over one-half of his support and is, or was at the time of the member's or retired member's death, actually residing in the household of the said member or retired member; or

"(g) An unmarried legitimate child (including an adopted child or stepchild) who (i) has passed his twenty-first birthday, if the child is incapable of self-support because of a mental or physical incapacity that existed prior to his reaching the age of twenty-one and is, or was at the time of the member's or retired member's

death, in fact dependent on him for over one-half of his support, or (ii) has not passed his twenty-third birthday and is enrolled in a full-time course of study in an institution of higher learning as approved by the Secretary of Defense or the Secretary of Health, Education, and Welfare and is, or was at the time of the member's or the retired member's death, in fact dependent on him for over one-half of his support."

Physicians Available For Temporary Work

A number of Ohio-licensed physicians have listed themselves with the Physicians Placement Service of the Ohio State Medical Association as available for temporary positions while they await military service.

Physicians needing a locum tenens or knowing of short-term opportunities for medical doctors, are requested to notify, or refer inquiries to, the Physicians Placement Service, Ohio State Medical Association, 79 E. State St., Columbus 15, Ohio.

"Mechanical Quackery" Booklet May Warn Unsuspecting Patients

"Mechanical Quackery" is the title of a new pamphlet published by the Bureau of Investigation of the American Medical Association for the information of the public.

It tells of ways in which the public is duped by quack machines and gadgets; contains pictures and descriptions of many notorious phony devices; and lists six characteristics which are generally of help in identifying a quack practitioner.

As the booklet states, "Today there are thousands of quacks promising quick cures for every disease known. They extort millions of dollars annually from their gullible patients. . . ."

The booklet is available to state and county medical societies in quantity, on request. It is also used to accompany the American Medical Association exhibit on mechanical quackery.

Individual physicians may find it useful for their waiting rooms and for the information of their patients.

Order from Mr. Oliver Field, Director of the Bureau of Investigation, American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois.

Dr. Oliver Cope, Boston surgeon and authority in the field of endocrinology, was guest lecturer at the University of Cincinnati College of Medicine early in June, at the invitation of Dr. William Altemeier, chairman of the Department of Surgery. He also addressed the College of Medicine Alumni Association at its annual meeting.

AMA Annual Session . . .

More Than a Hundred Ohio Physicians Take Part in Meeting in Chicago, Present Exhibits, Give Lectures on Program or Otherwise Participate

MANY Ohioans took prominent parts in the program of the American Medical Association Annual Session held in Chicago, June 11-15, presenting exhibits or otherwise participating in the session, according to the official program printed in the *Journal of the AMA*.

A story on the business transacted at the meeting will appear in the August issue of *The Journal*.

Following are the names of Ohio physicians listed in the program with a brief description of the part each played, subject of paper presented or other activity performed:

Dr. Irvine H. Page, research director of Cleveland Clinic, participated in discussion on Cardiac Arrhythmias. He further participated as a member of the Executive Committee of the Section on Experimental Medicine and Therapeutics.

Dr. Frank H. Mayfield, professor of neurosurgery, University of Cincinnati, spoke on "The Surgical Aspects of Crash Injuries,"—one of a series of talks on crash injuries.

Dr. B. B. Sankey, Cleveland, opened discussion on a lecture on "Surgeon-Anesthetist Teamwork in Operating Room."

Dr. J. Jay Jacoby, Columbus, presented a paper on "Transtacheal Resuscitation," before the Section on Anesthesiology.

DERMATOLOGY

Dr. Raymond R. Suskind, Cincinnati, participated in a Symposium on Cosmetics, presenting the introduction and discussing the subject, "Cutaneous Effects of Soaps and Detergents," during the meeting of the Section on Dermatology.

Dr. Roy L. Kile, Cincinnati, presented a paper on the subject, "How Communicable Are Warts?" before the Section on Dermatology.

Dr. F. Mason Sones, Jr., Cleveland, participated in a panel discussion on "Abnormalities of the Heart and the Great Vessels," presenting the internist's point of view.

Dr. Arthur C. Corcoran, Cleveland, participated in a Symposium on the Management of Hypertension, discussing the subject, "Antihypertensive Drugs and the Problems of Hypertensive Disease," before the Section on Experimental Medicine and Therapeutics.

Dr. John D. Battle, Jr., Cleveland, opened discussion on a paper, "Blood Disorders Caused by Drug Sensitivity," before a joint meeting of the Section on Experimental Medicine and Therapeutics and the Section on Internal Medicine.

Dr. Bruce K. Wiseman, Columbus, opened discussion on lecture, "Newer Agents in the Treatment of Leukemia," before the foregoing session.

Drs. Thomas Hale Ham, Russell Weisman, Jr., and Carl F. Hinz, Jr., all of Cleveland, presented the subject, "The Hemolytic Anemias—Congenital, Hereditary and Acquired," before the same meeting.

Dr. R. B. Turnbull, Jr., Cleveland, presented a paper on "Postoperative Staphylococcal Enteritis," before the Section on Gastroenterology and Proctology.

Dr. George Crile, Jr., Cleveland, took part in a panel discussion on Present Trends in Treatment of Duodenal Ulcer, before the Section on Gastroenterology and Proctology.

Dr. E. Perry McCullagh, Cleveland, participated in a panel conference and symposium on Endocrine Problems as Encountered in General Practice, before the Section on General Practice.

Drs. Bernard L. Brofman and Mortimer L. Siegel, Cleveland, spoke on "Medical Evaluation of the Beck Operation for Coronary Artery Disease," before the Section on General Practice.

Dr. A. Carlton Ernstene, Cleveland, is secretary of the Section on Internal Medicine.

Dr. Penn G. Skillern, Cleveland, was co-author of a paper on "The Use of the TSH test in the Diagnosis of Thyroid Disease," presented before the Section on Internal Medicine.

Dr. A. C. Corcoran, Cleveland, opened discussion on a study report, "Natural History of Glomerular Nephritis: A Report of Patients Treated from Ten to Twenty-Five Years After the Acute Stage," before the Section on Internal Medicine.

E. N. T.

Dr. Gerson Lowenthal, Cincinnati, opened discussion on a paper, "Fractures of the Facial, Orbital, Maxillary Bones, and Their Management, before the Section on Laryngology, Otology and Rhinology.

Dr. S. C. Missal, Cleveland, presented a paper on "Clinical Evaluation of Food Sensitization in Perennial Nasal Allergy," before the same section.

Dr. Robert S. Martin, Zanesville, opened discussion on a paper, entitled "Modern Treatment of Sinusitis," before the Section on Laryngology, Otology and Rhinology.

Dr. Clarence W. Engler, Cleveland, participated in a symposium on otolaryngologic therapy, discussing the subject, "Treatment of Tinnitus," before the Section on Laryngology, Otology and Rhinology.

Dr. Charles L. Leedham, Cleveland, was a delegate of the Section on Military Medicine.

Drs. Terence F. McGuire, G. Douglas Talbott,

Stanley C. White and Donald A. Rosenbaum, all of Dayton, presented a study before the Section on Military Medicine, entitled "Cardiovascular Effects of Pressure Breathing with Graded Degrees of Compensation."

Dr. John H. Dingle, Cleveland, opened discussion on a talk, entitled "Acute Respiratory Illness Caused by RI Viruses: A Military Problem," before the Section on Military Medicine.

Dr. W. James Gardner, Cleveland, opened discussion on a paper, "Experience with Cordotomy at the High Cervical Level," before the Section on Nervous and Mental Diseases.

Dr. Kenneth H. Abbott, Columbus, opened discussion on a talk entitled "Whiplash Injuries: A Survey of 100 Cases Subsequent to Settlement of Litigation," before the Section on Nervous and Mental Diseases.

OPHTHALMOLOGY

Dr. William H. Havener, Columbus, was co-author of a paper, "Hazards of the Use of Sympathomimetic Drugs in Ophthalmology," presented before the Section on Ophthalmology.

Dr. David Volk, Cleveland, presented a paper before the Section on Ophthalmology on the subject, "Observations on the Dissimilarity Between the Retinal Capillary Microaneurysm in Diabetes Mellitus and the Nodule of Inter-capillary Glomerulosclerosis."

Dr. Lorand V. Johnson, Cleveland, was secretary-treasurer of the Association for Research in Ophthalmology, which presented a program.

Drs. Rudolf F. Binder and Hertha Binder, Cleveland, presented a report, entitled "Experiments on Woundhealing in the Endothelium of the Cornea," at the meeting of the Association for Research in Ophthalmology.

Drs. E. W. Purnell, C. E. Melton, Jr., and E. Q. Adams, Cleveland, presented a study on "Measurements of Aqueous Outflow in Enucleated Eyes," before the Association for Research in Ophthalmology.

Drs. Anita P. Gilger and Albert M. Potts, Cleveland, gave a report on the subject, "Studies on the Visual Toxicity of Methanol, No. 9: The Effect of Ethanol and Methanol Poisoning on the Rhesus Monkey," before the foregoing session.

Drs. David Volk and Jan H. Bruell, Cleveland, were co-authors of a paper on the subject, "Eye Movements in an Adult with Cerebral Hemispherectomy for Tumor," presented before the same group.

Drs. Albert M. Potts and B. Cohen, Cleveland, were co-authors of a report, entitled "Corneal Transport of Lactic Acid as Measured with C-14 Lactate," also presented to the Association for Research in Ophthalmology.

Drs. Elmer J. Ballantine and Morton B. Waitzman, Cleveland, were co-authors of another paper presented to the foregoing group, entitled "Enzyme Systems Concerned with Oxidative Phosphorylation in Ciliary Processes."

Drs. George S. Phalen and J. I. Kendrick, Cleveland, presented a paper on "Compression Neuropathy of the Median Nerve in the Carpal Tunnel," before the Section on Orthopedic Surgery.

Dr. Austin B. Chinn, Cleveland, spoke on "Some Problems with Nutrition in the Aged," before the Section on Orthopedic Surgery.

Dr. Emmerich von Haam, Columbus, opened discussion on a paper, entitled "The Structure and Function of the Nongoitrous Thyroid Gland During Pregnancy," before the Section on Pathology and Physiology.

Dr. B. Black-Schaffer, Cincinnati, presented a paper on the subject, "Infantile Hyperplastic and Hypertrophic Cardiomegaly and Endocardial Fibroelastosis," before the Section on Pathology and Physiology.

Dr. Walter J. Zeiter, Cleveland, was secretary of the Section on Physical Medicine.

Dr. Paul A. Nelson, Cleveland, gave a talk on "Treatment of Cervicodorsal Outlet Syndrome," before the Section on Physical Medicine.

Dr. Nadine Coyne, Cleveland, opened discussion on a paper, entitled "Evaluation of End-Results in Anterior Poliomyelitis," presented before the Section on Physical Medicine.

Dr. Keith C. Keeler, Akron, presented a paper before the same section on "Conservative Therapy in Peripheral Nerve Dysfunction."

Dr. Herman K. Helierstein, Cleveland, gave a talk on "Rehabilitation of the Cardiac Patient," before the Section on Physical Medicine.

Dr. Justus F. Lehmann, Columbus, opened discussion on a paper, entitled "The Present Status of Ultrasound in Medicine," before the Section on Physical Medicine.

PREVENTIVE AND INDUSTRIAL MEDICINE

Dr. Frank Princi, Cincinnati, was secretary of the Section on Preventive and Industrial Medicine and Public Health.

Dr. Paul A. Davis, Akron, represented the Section on Preventive and Industrial Medicine and Public Health to the Scientific Exhibit.

Drs. Milton D. Levine and Murray B. Hunter, Bellaire, presented a paper on the subject, "Pneumoconiosis of Soft Coal Miners in the Ohio Valley, a Clinical Study," before the Section on Preventive and Industrial Medicine and Public Health.

Dr. Mitchell R. Zavan, Cincinnati, spoke on the subject, "Radiation: Helpful or Harmful?" before the same section.

Drs. Charles M. Greenwald, Thomas Meaney and C. Robert Hughes, Cleveland, were co-authors of a paper presented on the subject, "Chordoma: An Uncommon Destructive Lesion of the Cerebrospinal Axis," before the Section on Radiology.

Dr. Oscar A. Turner, Youngstown, opened discussion on the foregoing paper.

Dr. Robert M. Zollinger, Columbus, is a

member of the Executive Committee of the Section on Surgery, General and Abdominal.

Dr. George Crile, Jr., Cleveland, opened discussion on a talk on the subject, "Diagnosis and Treatment of Thyroiditis," before the Section on Surgery, General and Abdominal.

Dr. Charles C. Higgins, Cleveland, opened discussion on a lecture, entitled "The Immediate Management of the Injured Ureter," before the Section on Surgery, General and Abdominal. He also opened discussion on a paper on the subject, "Vesicointestinal Fistula," presented before the Section on Urology. He is a member of the Executive Committee of the Section on Urology.

MOTION PICTURES

The following Ohioans took part in the Motion Picture Program—the subject of the picture being indicated:

Drs. Karl P. Klassen and Charles V. Meckstroth, Columbus, "The Actions of the Human Heart Valves."

Dr. Charles H. Brown, Cleveland, "Liver Biopsy with the Vim Silverman Needle."

Drs. Philip F. Partington and Maurice D. Sachs, Cleveland, "Operative Cholangiography."

Dr. Claude S. Beck, Cleveland, "Resuscitation for Cardiac Arrest."

EXHIBITS

A number of Ohioans presented Scientific Exhibits or otherwise participated in the exhibits:

Dr. Ralph G. Carothers, Cincinnati, was chairman of the Special Exhibit on Fractures. The following physicians participated in the Special Exhibit on Fractures as demonstrators: Drs. Herbert L. Brumbaugh, Dayton; F. Paul Duffy, Cincinnati; Nicholas J. Giannestras, Cincinnati; Charles U. Hauser, Hamilton; Harold E. Snedden, Sandusky; and Edgar H. White, Cincinnati.

Dr. J. Jay Jacoby, Columbus, co-sponsor of an exhibit, "Postgraduate Education in Anesthesia," in the Section on Anesthesiology.

Drs. Neil C. Andrews and Karl P. Klassen, Ohio State Medical Center, Columbus, "Eight Years' Experience with Pulmonary Biopsy," Section on Diseases of the Chest.

Drs. Eduard Eichner and Helen Eichner, Mount Sinai Hospital, Cleveland, "Premenstrual Tension Syndrome," in the Section on General Practice.

Dr. S. William Simon, Brown General Hospital, Veterans Administration Center, Dayton, "Evaluation of Xanthine Drugs in Chronic Pulmonary Disease: Use of a New Respiratory Index," Section on General Practice.

Drs. Penn G. Skillern, George Crile, Jr., E. Perry McCullagh, John B. Hazard, Helen Brown and Lena A. Lewis, the Cleveland Clinic Foundation, "Struma Lymphomatosa: Primary Thyroid Failure with Compensatory Thyroid Enlargement," Section on Internal Medicine.

Dr. Raymond L. Hilsinger, Cincinnati, "Headache: Diagnosis and Treatment," Section on Laryngology, Otology and Rhinology.

Dr. Keith W. Sheldon, Cleveland, "Strokes: A Short Course in Diagnosis and Treatment," Section on Nervous and Mental Diseases.

Drs. Judith H. Rettig and Carl M. Rosenberg, Columbus State School, "The Effect of Chlorpromazine on the Institutional Care of Retarded Children"; Section on Nervous and Mental Diseases.

Drs. Harry W. Slade and Simon Spendiarian, Western Reserve University School of Medicine and City Hospital, Cleveland, "Progress Radiographs in Cranial Trauma"; Section on Nervous and Mental Diseases.

Dr. David Volk, Western Reserve University School of Medicine, "Aids to Subnormal Vision"; Section on Ophthalmology.

Dr. George S. Phalen and James I. Kendrick, Cleveland Clinic, "Compression Neuropathy of the Median Nerve in the Carpal Tunnel"; Section on Orthopedic Surgery.

Dr. Robert M. Stecher, Western Reserve University School of Medicine, Cleveland, "Heredity of Short Thumbs"; Section on Orthopedic Surgery.

Dr. E. L. Burns, Toledo, participated as a demonstrator in the Special Exhibit on Fresh Tissue Pathology in the Section on Pathology and Physiology.

Drs. Mieczyslaw Peszczyński and Jan H. Bruell, Highland View Hospital and Western Reserve University School of Medicine, Cleveland, "Disturbances of Space Perception in Hemiplegics and Its Relation to Gait Training"; Section on Physical Medicine.

Drs. Harry T. Zankel, Reginald A. Shipley and Richard E. Clark, Veterans Administration Hospital, Cleveland, "Venous Circulation Studies of the Lower Extremity Using a Radioactive Tracer"; Section on Physical Medicine.

Dr. Bruno Gebhard, Cleveland Health Museum, "Health Consultation with Exhibits"; Section on Preventive and Industrial Medicine and Public Health.

Dr. M. S. Schulzinger, Cincinnati, "Accident Syndrome: A Clinical Approach"; Section on Preventive and Industrial Medicine and Public Health.

Drs. Charles M. Greenwald, Thomas F. Meaney and C. Robert Hughes, Cleveland Clinic, "Chordoma"; Section on Radiology.

SURGERY

Dr. Edwin H. Ellison, Ohio State University Health Center, Columbus, "The Ulcerogenic Tumor of the Pancreas"; Section on Surgery, General and Abdominal.

Drs. John J. Cranley and Raymond J. Krause, Good Samaritan and Cincinnati General Hospitals, Cincinnati, "Obliterative Arterial Disease of the Lower Extremity—Clinical, Laboratory and Radiographic Correlations"; Section on Surgery, General and Abdominal.

Drs. Claude S. Beck, David S. Leighninger,

and Bernard L. Brofman, University Hospitals, Cleveland, "Operation for Coronary Artery Disease," Section on Surgery, General and Abdominal.

Drs. William E. Abbott, Harvey Krieger, and Stanley Levey, University Hospitals of Cleveland and Western Reserve University School of Medicine, "Parenteral Alimentation," Section on Surgery, General and Abdominal.

Drs. Eugene F. Poutasse, William J. Engel and Harriet Dustan, Cleveland Clinic, "Reversible Hypertension Due to Renal Artery Disease," Section on Urology.

Salk Vaccine Still Limited, but Supply To Ohio Is on the Increase

The amount of Salk polio vaccine coming into Ohio has continued to increase, according to reports from the Ohio Department of Health. During the period May 18 - June 18, the amount received was 592,173 cc., about a 12 per cent increase over the previous 30-day supply.

Of the amount received, 515,681 cc. went into commercial channels and 66,492 cc. was purchased by the Department for distribution to health agencies.

The total amount of Salk vaccine received in Ohio since August of 1955, as of June 18, was 2,721,301 cc., of which 1,977,499 cc. went into commercial channels and 743,802 cc. were purchased for public agency distribution.

Percentage-wise, the distribution of vaccine for the period May 18 - June 18 was about 89 per cent commercial to 11 per cent agency. This is about the same distribution as for the previous 30-day period and brings the over-all distribution to a ratio of approximately 73:27.

With the approach of the polio season the Ohio Department previously announced its recommendation that one shot of vaccine be given to each child in the age group 1-15 and pregnant women before any additional second or third inoculations are given, as long as the supply is limited. This policy is still in effect.

One matter of policy which health officials would like to call to attention of physicians is that in regard to reports on the use of polio vaccine. A number of physicians have been sending in cards reporting on distribution of commercial vaccine purchased by them from pharmaceutical houses. No reports on commercial vaccine are required. In fact, such reports complicate the work of local health commissioners and the Ohio Department of Health. There is a required report on vaccine received from local health agencies and purchased with Federal funds, but only the vaccine secured through that source should be reported.

Nine laboratory refresher courses covering the serology of syphilis will be given at the Venereal Disease Research Laboratory in Chamblee, Georgia, August 1956 to May 1957.

Two Ohioans Head Joint Committee on Health Problems in Education

Two Ohioans have been elected to the top offices of the Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association, at a meeting held recently in Washington, D. C.

Delbert Oberteuffer, Ph. D., professor and chairman of Physical Education, Ohio State University, has been elected chairman of the ten-member committee, and Carl A. Wilzbach, M. D., health commissioner of Cincinnati, and chairman of the OSMA Committee on Education, is the new vice-chairman. Fred V. Hein, Ph. D., consultant with the AMA Bureau of Health Education, is secretary.

Formed in 1911, this is the oldest joint committee of either parent organization. It has published numerous booklets on school health during that period. The latest, just off the press is "Health Aspects of the School Lunch Program." All are available from the AMA Bureau of Health Education.

The functions of the Committee are as follows:

1. To provide a means for interchange of information between the professions of education and medicine on matters related to the health of children and youth.

2. To develop effective liaison between the various departments of the NEA and the AMA on school health matters.

3. To serve as a board of review on controversial issues with medical and educational implications, to which educators, physicians, and others concerned with school health may submit inquiries in regard to policy on health matters.

4. To promote cooperation and to foster helpful relationships among medical, educational, public health, and other groups concerned with school health.

5. To participate with other qualified or recognized groups, having a continuing interest in school health, in developing and implementing sound principles and programs.

6. To formulate and issue statements setting forth principles and policies as the best conclusions available from research, knowledge of child growth and development, or experience and opinion in the field.

7. To publish pertinent materials on school health designed to meet evident needs and to furnish guidance for those concerned with the health and education of children and youth.

8. To cooperate with appropriate groups in furthering adequate preparation in school health for administrators, teachers, and health service personnel.

Dr. Eleanor Schmidt, Athens, director of the Ohio University Health Center, was re-elected president of the Ohio College Health Association which met in Columbus recently.

OMI WILL MAKE INDEMNITY CHECK PAYABLE TO BOTH SUBSCRIBER AND PHYSICIAN IF AUTHORIZATION FROM SUBSCRIBER IS SUBMITTED

BY action of the House of Delegates at the 1956 Annual Meeting, Cleveland, The Journal was directed to give publicity to the following:

Any physician rendering service to a subscriber of Ohio Medical Indemnity, Inc., who may want his name included on the indemnity check issued to the subscriber may ask that this be done by requesting the subscriber to sign an authorization to that effect.

The authorization carrying the legal signature of the subscriber should be clipped to the claim form sent to OMI.

It is recommended that the authorization appear on a sheet of paper at least 8½x11 inches in size. This will assist Ohio Medical in handling the authorization rapidly and efficiently.

In all cases where a properly signed authorization is received, Ohio Medical issues the indemnity check in the name of the subscriber and the physician who rendered the service.

The authorization need not be in formal, legal language but merely a statement by the subscriber that he or she wants the check made out jointly.

Since many physicians prefer, for various reasons, not to follow this procedure, OMI does not have a formal authorization blank for use of its subscribers. However, it will comply with a written statement properly signed by a subscriber authorizing OMI to make the indemnity check payable jointly to the subscriber and the physician.

Two Physicians Receive Ohio State Awards

Two physicians were among six persons honored with the Distinguished Service Award of Ohio State University at commencement exercises in June. The awards were established by the Board of Trustees in 1952 and are presented in recognition of outstanding service to the University.

The two recipients are Dr. Russell G. Means, associate clinical professor of otolaryngology and a member of the faculty for 34 years; and Dr. John W. Wilce, professor of clinical and preventive medicine and director of the University Health Services. Dr. Wilce has been a faculty member for 43 years and served as head football coach from 1913 to 1929.

Public Health Meeting Scheduled In Atlantic City, Nov. 12-16

The American Public Health Association has announced its 8th annual meeting to be held in Convention Hall, Atlantic City, N. J., November 12-16. More than 4,000 public health workers from all parts of the free world are expected to attend. Additional information may be obtained from the American Public Health Association, 1790 Broadway, New York, N. Y.

Committee on Rehabilitation Authorized by AMA Board

The Board of Trustees of the American Medical Association has authorized establishment of an Intra-Association Committee on Rehabilitation, to be composed of one representative each from the Council on Medical Service, Council on Medical Education and Hospitals, Council on Mental Health, Council on Industrial Health, Council on Medical Physics, Council on Foods and Nutrition and the Bureau of Health Education.

The Committee will function as a study group and clearing house for rehabilitation matters and will submit recommendations to the Board of Trustees on its findings.

Course in Postgraduate Gastroenterology

The American College of Gastroenterology announces that its Annual Course in Postgraduate Gastroenterology will be given at The Roosevelt in New York City, on October 18, 19, and 20. For further information and enrollment write to the American College of Gastroenterology, Department P.G., 33 West 60th Street, New York 23, N. Y.

Conference on Physicians and Schools at Lake Hope



Among those who attended the Lake Hope Conference on Physicians and Schools were the following: (front row, left to right)—Dale Hudson, M. D.; Lloyd F. Shaheen, D. D. S.; Ralph K. Ramsayer, M. D.; James I. Rhiel, M. D.; (back row, beginning at left)—Kurt C. Becker, M. D.; Thomas E. Shaffer, M. D.; Margaret O'Neal, M. D.; Lee Traul, M. D.; C. H. Thompson, M. D.; Fred Hein, Ph. D.; Charles L. Kagay, M. D.; and R. C. Fox, M. D.

* * *

County Medical Society school health committees were well represented at the Third Annual Conference on Physicians and Schools, held May 8-10 at Lake Hope, Zaleski.

Each year, eight to ten counties are selected for representation, and about a dozen representatives of the fields of medicine, education, public health, nursing and parent groups come to the conference as a team.

Serving as the out-of-state guest consultant for the conference for the second successive year was Fred V. Hein, Ph. D., Chicago, consultant in health and fitness, Bureau of Health Education, American Medical Association.

The conference is financed by the following organizations, all members of the State Planning Committee for Health Education, which is the sponsoring organization: Ohio Department of Health, Ohio State Medical Association, Ohio Education Association, Ohio Tuberculosis and Health Association, Ohio State Heart Association and the Ohio Department of Mental Hygiene and Correction.

Physicians in attendance at the conference included the following: Dr. Thomas E. Shaffer, Columbus, chairman of the OSMA Committee on School Health; Dr. Charles L. Kagay, Dayton,

member of the OSMA Committee on School Health; Dr. Margaret O'Neal, Zanesville, chairman of the Muskingum County Medical Society School Health Committee and a member of the OSMA Committee on School Health; Dr. R. C. Fox, Green Springs, chairman of the School Health Committee of the Sandusky County Medical Society; Dr. A. F. Schultz, Fremont, chairman of the Public Relations Committee, Sandusky County Medical Society, and Sandusky County health commissioner; Dr. James I. Rhiel, Port Clinton, chairman of the School Health Committee, Ottawa County Medical Society, and a member of the OSMA Committee on Rural Health; Dr. R. K. Ramsayer, Canton, president of the Stark County Medical Society; Dr. Dale Hudson, Piqua, secretary of the Miami County Medical Society, and a member of the OSMA Committee on School Health; Dr. Kurt C. Becker, Troy, chairman of the School Health Committee of the Miami County Medical Society; Dr. C. H. Thompson, West Mansfield, Logan County Medical Society; and Dr. Lee Traul, chairman of the Committee on School Health, Logan County Medical Society.

Mr. Hart F. Page, secretary of the OSMA School Health Committee, served as finance chairman of the conference.

Do You Know? . . .

On the occasion of his 95th birthday on May 15, Dr. R. C. Paul, of Wooster, was the subject of a feature article in the *Wooster Daily Record* by staff writer Clif Bushnell. The author traced the life of his subject from earliest times, through his preceptorship and medical schooling to the present. Fellow members of the Kiwanis Club participated in celebration of a memorable birthday. Dr. Paul is still in practice.

* * *

After an absence of five years from Ohio, Dr. Ewing H. Crawfis has returned and is now superintendent of the Cleveland Regional Treatment Center. Formerly he was with the Cleveland State Hospital. He has been deputy commissioner of health in California and later mental health commissioner in Arkansas.

* * *

Dr. S. J. Ellison, West Union, has announced his retirement after 52 years of practice in Adams County. He has served many years as a delegate to the OSMA from his county.

* * *

Dr. Charles A. Anderson, Warren, was elected president of the Ohio Society, Sons of the American Revolution, at the 67th annual conference in Springfield.

* * *

Dr. William Knapp, Zanesville, was elected president of the Inter-State Orthopedic Society, an organization of physicians from West Virginia, western Pennsylvania and eastern Ohio.

* * *

Dr. Edward A. Gall, Cincinnati, has been re-elected secretary of the American Association of Pathologists and Bacteriologists which met in Cincinnati April 26-28. Early in May he addressed the Wisconsin State Medical Association on the subject, "Aids in the Diagnosis of Liver Disease," and the Wisconsin Society of Pathologists on "Some Pathological Features of Obstructive and Viral Hepatitis."

* * *

Dr. William H. Clatworthy, Jr., is scheduled to address the International Congress of Pediatric Surgeons in London, England, in July. He will combine the trip with a tour of other European countries with his family, before returning to Columbus.

* * *

Dr. A. Carlton Ernstene, Cleveland, spoke on "The Treatment of Coronary Heart Disease," at the Wayne University Assembly Annual Clinic Day, in Detroit, May 9.

* * *

Dr. Bert Seligman, Toledo, spoke on the subject, "Treatment of Chronic Venous Insufficiency," at the second annual meeting of the American College of Angiography in Chicago, June 9-10.

Dr. Richard L. Meiling, President of the Ohio State Medical Association, and Earl F. Morris, President of the Ohio State Bar Association, are members of the Class of 1930 of Wittenberg College. They also went through grade school and high school in Springfield in the same class, and are now residents of Columbus. Their Alma Mater has recognized their attainments by awarding each of them with an honorary degree; Dr. Meiling, the degree of doctor of science in 1950, and Morris, the degree of doctor of laws in 1955.

* * *

Dr. John Holmes Dingle, professor in the School of Medicine, Western Reserve University, has been named a member of the special committee appointed to recommend a plan for distribution of the Ford Foundation's \$90,000,000 to the nation's privately supported medical schools.

* * *

Dr. Carl W. Wiggers, veteran teacher of physiology at Western Reserve University School of Medicine, and now consultant at Cleveland Clinic, gave the commencement address at Albany Medical College, Albany, N. Y.

* * *

Mr. Oliver Field, director of the Bureau of Investigation of the American Medical Association, was in Columbus where he addressed the Columbus Bar Association on the subject, "Quackery in Medicine," on May 16. Mr. Field is a member of the Illinois Bar.

* * *

Dr. Jonathan Forman, as president of the Friends of the Land, arranged and conducted a symposium on the progress of soil and water conservation on April 27 at the William Penn Hotel in Philadelphia. He also was the guest speaker at the annual banquet of the joint meeting of the American Academy of Nutrition and the American Nutrition Society in Hotel Statler, Los Angeles, Calif., May 19, where he spoke on the subject, "Your Health is Your Personal Responsibility." On the following day he addressed the American Nutrition Society, on "Nature Is Always Trying To Strike a Balance," a discussion of the ecology of health and the imbalances which lead to disease.

* * *

Personnel of St. John's Hospital, Cleveland, honored three physicians at a dinner for faithful service on the staff. They are: Dr. Lothair J. Carson, head of the Department of Dermatology, 32 years; Dr. James T. Collins, chief of eye, ear, nose and throat section, 30 years; and Dr. William E. Dwyer, associated with the Department of Obstetrics, 35 years.

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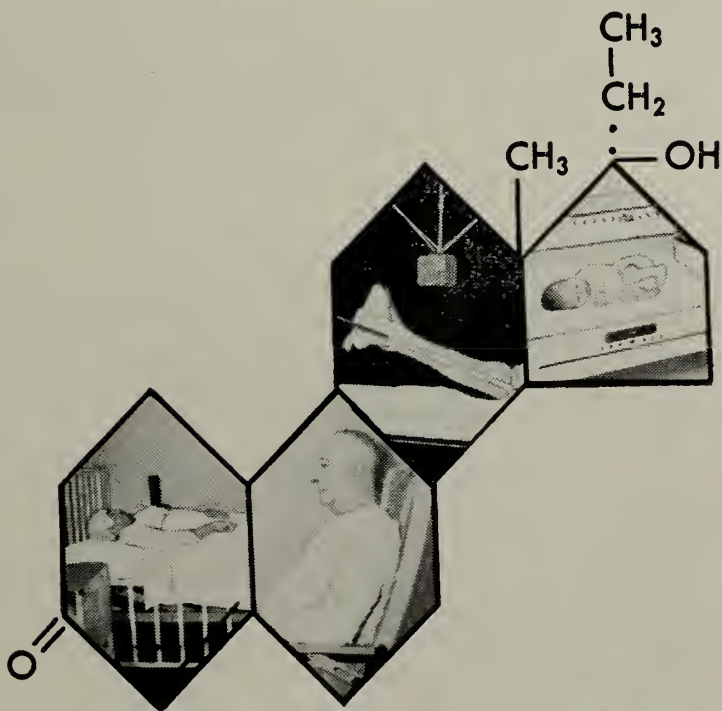
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In Our Opinion:

Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

NEWSPAPER BOYS HONOR MEDICAL SOCIETY P. R. CHAIRMAN

When representatives of the press honor the chairman of the public relations committee of a County Medical Society, brother, that IS news!

It actually happened in Akron recently. Dr. Millard C. Beyer, a former president of the Summit County Medical Society and currently chairman of the Society's public relations committee, was presented with the first Public Service Award of the Buckeye Chapter of Sigma Delta Chi, national professional journalism fraternity, for excellence in press relations.

The presentation was the one serious note at the chapter's Gridiron Dinner. Over 450 attended the affair, including many of the top local figures in politics, industry, business and organized labor, as well as some state and national celebrities.

Loris Troyer, editor of the *Kent Courier-Tribune* and SDX chapter president, awarded a plaque to Dr. Beyer, thanking him on behalf of all newsmen "for helping to tell the story of the medical profession."

Congratulations, Dr. Beyer! This sort of honor does not come easy. It has to be earned—and you've done it.

HOW TO MAKE CANCER REGISTRY A SUCCESS

Ohio now has a going Central Cancer Registry. Being voluntary in all respects, its success will depend to a large extent on the cooperation and support of practicing physicians and hospital managements. How have ventures like this worked elsewhere? Connecticut has had one in operation for approximately 20 years. Judging from the following editorial in the May issue of the *Connecticut State Medical Journal*, the Connecticut cancer registry has proved quite a success and has had excellent professional support:

"Connecticut physicians justifiably can be proud of their unique statewide Cancer Register, now reaching a maturity not equalled in the United States. Material collected from a relatively stable population for more than twenty years is ready for searching analyses as reported in this issue of the *Journal* and earlier by Ottenheimer and Oughterson on cancer of the colon.

"While it is true that fostering agencies have guided this program, its success is the sole result of interested and enthusiastic support by the practicing physicians in the State. Busy doctors have given liberally of their time in providing data on new cancer cases and data on follow-up.

"The collection of information over the period of its development has provided this register with data to be of inestimable value over the years ahead. As the facts that lie hidden in the

archives of the State Register are sifted and correlated, new knowledge of cancer will be revealed as related to detection, epidemiology and efficacy of therapy. Knowledge of this nature can only be of aid to the patient, the doctor and cancer research with a very broad implication.

"Connecticut physicians have demonstrated very well to the entire medical profession the achievements that can be obtained when well conceived programs receive the professional support of a large number of contributors. Such success can only raise the question whether or not progressive clinical investigations on a similar cooperative basis could be undertaken with the same degree of success to the mutual benefit of all concerned in the attempt to improve the care of patients with neoplastic disease."

If it can be done in Connecticut, it can be done in Ohio.

WE DON'T MIND TAKING A BOW OCCASIONALLY

In an organization like the Ohio State Medical Association, personal services are the big stock in trade. Those who have been in management posts have tried their best to give prompt and efficient services to all OSMA members. The following letter received by the Executive Secretary from a member in military service would indicate that the effort has not been in vain:

"Thank you for your letter of March 13, 1956. I wish to compliment the Ohio State Medical Association and you for the very competent way you keep the Ohio M.D.'s in military service informed as to the events and activities of medicine in Ohio and elsewhere. I have run into numerous M.D.'s from Ohio and they all feel the same way."

It's nice to get letters like this one. Members wherever they may be can be sure that the Columbus Office will do its level best to keep them informed and give them good service.

OHIO AND SCHOOL HEALTH ACTIVITIES

Two Ohioans have been named to the top offices of the Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association. The new chairman is Delbert Oberteuffer, Ph. D., head of the department of physical education, Ohio State University. The vice-chairman is Carl A. Wilzbach, M. D., Cincinnati, chairman of the Committee on Education, Ohio State Medical Association, member of the School Health Committee of the Association and health commissioner of the city of Cincinnati.

The honor which goes with the offices is well deserved by these men. They have made large contributions to health activities as they relate

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to education. Recognition of them is a flower in Ohio's lapel. Also, we like to think that their selection indicates that Ohio is in the front rank when it comes to activity in this field. If that is true, then the Ohio State Medical Association can take a bow as it has done much through its School Health Committee to stimulate thought and action throughout the state on matters relating to school health, school medical problems, etc.

YOU CAN GET NEW AMERICAN MEDICAL DIRECTORY NOW

Believe it or not, the new American Medical Directory is out! The new 3,122 page 1956 edition contains a wealth of material. It was worth waiting for. If you want a copy, order it from Philip E. Mohr, editor of Directory, AMA, 535 N. Dearborn Street, Chicago 10. It costs \$30.00—a bargain in the light of its value and content.

Among the many interesting facts carried in the new directory is the figure on the total number of physicians in the U.S. compared to 1950. The total figures are 218,061 in 1956 and 201,277 in 1950. Ohio showed an increase of 990 during the six year period—the number in Ohio in 1956 being 10,874.

GENERAL ELECTRIC MAKES SOUND DECISION

In a letter to the Ohio State Medical Association, Dr. E. M. Kline, medical director of the Lamp Division, General Electric Company, states that his company will follow the recommendations made by the Association regarding a medical examination program for the company's employees. These recommendations were drafted after very careful study and many conferences. They were published on pages 413-414 of the April, 1956, issue of *The Ohio State Medical Journal*.

One of the recommendations was that every possible effort be made to maintain and further the usual doctor-patient relationship in such a program.

Another one was that discussions be held with the local County Medical Society before any such program is put into effect.

Dr. Kline and the General Electric Company are to be congratulated for having agreed to suggestions made by the Association. Obviously, they are to be congratulated also for having shown such a direct and active interest in the health of the company's employees.

Industry and the medical profession must pull together on matters of this kind. They can do so providing the leaders on both sides take a reasonable point of view and are willing to sit down around the conference table to work out mutually acceptable methods to accomplish their aim—better health and more health protection for industrial workers.

If all industries would make the same de-

cision General Electric, Lamp Division, has made, namely, to work closely with local medical societies on such activities, everyone will benefit.

UNION CHIEF WAVES BIG STICK AT ST. VINCENT'S

No opinion need be expressed by us on the following editorial which appeared in the May 15 issue of the *Toledo Blade* since the editorial itself says a mouthful and expresses quite adequately our views about the sorry mess:

"In what must surely be one of the weirdest labor moves in history, A. R. Bowles, business agent for the Building Service Employees, proposed last week that all Toledo union members stop making gifts to the hospitals and Catholic organizations of the city because St. Vincent's Hospital has declined to bargain with his union.

"(Upon second thought, even Mr. Bowles appears to have got some glimmering of the preposterousness of his proposition and was reported to be considering some changes in it.)

"Legally, of course, he doesn't have a leg to stand on. As Mother Dorothy Reese, mother superior of the Grey Nuns, Sisters of Charity, has pointed out, the Taft-Hartley Act has specifically exempted hospitals from any requirement to bargain with a union. As nonprofit organizations engaged solely in serving the sick of the community, they have been given this privileged status because obviously they should not be subject to external compulsions.

"Morally, of course, a boycott of our hospitals and Catholic organizations—which presumably, would be strictly financial and not personal in the case of union members needing hospital care—would be shameful. There has been no indication that St. Vincent's has been treating any of its employees unfairly. In fact, Mr. Bowles has been quoted as saying that if the hospital will give the union a contract he won't make any other demands on it—not yet.

"But it is the practical aspect of this move which should give the people of Toledo the greatest concern. If it should succeed, then a labor leader who has demonstrated his utter irresponsibility would obtain a foothold at St. Vincent's and perhaps move along to our other hospitals. And, forever after, the care and treatment of all our sick would be subject in some degree to the whims and caprices of the business agent of the BSE!

"Toledo is a strong union town, and most of our people believe in union principles. But we cannot believe that even our union members want this Mr. Bowles to be telling our good Grey Sisters and nurses and doctors how to run St. Vincent's or any of our other hospitals."

"Your Radiologist"

The American College of Radiology is issuing a new publication called "Your Radiologist." From a journalistic standpoint it is professional in tone and readable by the layman, telling the story of the radiologist and his role in modern medical care, with excellent illustrations. The publication is recommended for placing in reception rooms in private offices and hospital departments of radiology. Editorial offices are at 20 N. Wacker Dr., Chicago 6.



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In Memoriam . . .

Seth E. DeMuth, M.D., Hicksville; Eclectic Medical College, Cincinnati, 1899; aged 80; died May 11; recent member of the Ohio State Medical Association and the American Medical Association. Upon completion of his medical training Dr. DeMuth began practice in Cecil in association with his father, the late Dr. Fisher F. DeMuth. He moved to Hicksville in 1921 and remained in practice until a few days before his death. He was a recipient of the State Association's 50-Year Award. Active in community affairs, he was a member of the Masonic and Elks Lodges. Surviving are his widow, and two sons, one of whom is Dr. Forder F. DeMuth, also of Hicksville; also two brothers, including Dr. George W. DeMuth, of Sherwood.

Edward B. Doan, M.D., Miamisburg; Cleveland-Pulte Medical College, 1899; aged 87; died May 17; member of the Ohio State Medical Association through 1944; recipient of the State Association's 50-Year Award. Dr. Doan began his practice in West Carrollton in 1899 and moved to Miamisburg in 1914. He retired in 1942. For 20 years he served on the Montgomery County Board of Health. Other activities included membership in the local Rotary Club of which he was a charter member. Surviving are his widow, four sons, one of whom is Dr. Roscius Doan, also of Miamisburg.

Charles W. Emmons, M.D., Fairview Park; University of Wooster, Medical Department, 1906; aged 73; died May 3; member of the Ohio State Medical Association and the American Medical Association. Dr. Emmons had been in practice for more than 49 years, about 36 years in the Lakewood and Fairview Park area. He was a member of the Masonic Lodge and the Order of the Eastern Star. Survivors include his widow, a daughter and a sister.

Myer J. Gibans, M.D., Akron; University of Pittsburgh School of Medicine, 1905; aged 73; died May 18; member of the Ohio State Medical Association, the American Medical Association and the American Academy of Dermatology and Syphilology, the Society for Investigative Dermatology, former vice-president of the Cleveland Dermatological Society; recipient of the OSMA 50-Year Award. A native of Pittsburgh, Dr. Gibans practiced there before he moved to Akron where he practiced for 38 years. He was affiliated with Phi Chi Fraternity and Rosemont Country Club. Surviving are his widow, a son and a sister.

George Hermann, M.D., of near New Richmond; Eclectic Medical College, Cincinnati, 1916; aged 61; died May 23. Dr. Hermann practiced for many years in Cincinnati. Since 1950 he had

been chief surgeon of the First Regiment, Ohio Defense Corps. He was a member of several Masonic bodies. His widow survives.

Lindsay A. Jackson, M.D., Fort Myers, Fla.; Cleveland-Pulte Medical College, 1898; aged 80; died May 21. A former practicing physician of Columbus, Dr. Jackson had been living in Florida for the past eight years. He was a 32nd Degree Mason and a steward in the Methodist Church. Survivors include his widow and a sister.

Harold F. Minshull, M.D., New Lexington; Eclectic Medical College, Cincinnati, 1918; aged 60; died May 21; member of the Ohio State Medical Association. A native of Perry County, Dr. Minshull served all of his professional career in the New Lexington area. He was Perry County coroner and health commissioner for many years and three years ago also became health commissioner for Morgan County. He had given up private practice several years ago to devote all of his time to his public duties. Affiliations included memberships in the Masonic Lodge and the Methodist Church. Surviving are his widow, a daughter and his mother.

Benjamin David Osborn, M.D., Waldo; Starling Medical College, Columbus, 1897; aged 83; died May 3; member of the Ohio State Medical Association and the American Medical Association. Dr. Osborn moved to Waldo upon completion of his medical education and had been in practice there for more than 59 years. He was honored with the 50-Year Pin of the State Association. He was a former Marion County coroner and active in numerous community affairs. He was a member of several Masonic bodies, the Evangelical and Reformed Church and was a 50-Year member of the Knights of Pythias. His widow and a son survive.

Anthony F. Sibila, M.D., Cleveland; Western Reserve University School of Medicine, 1954; aged 28; died April 27. Dr. Sibila had completed an internship at St. John Hospital in December and was awaiting a residency at St. Luke's Hospital. He is survived by his widow, three children, his mother and a sister.

Robert A. Thornton, M.D., Columbus; Starling-Ohio Medical College, 1912; aged 67; died May 20; member of the Ohio State Medical Association and the American Medical Association. Dr. Thornton was a native of Washington Court House. Upon completion of his medical education, he remained in Columbus and continued in practice there for 43 years. A veteran of World War I, he served for 18 months in the Army Medical Corps. Other activities included memberships in the Methodist Church and several Masonic bodies including the

Consistory and Shrine. Surviving are his widow and a son.

Mary E. Tracy, M.D., Cincinnati; Cincinnati College of Medicine and Surgery, 1902; aged 85; died April 22. Dr. Tracy was a native of Hamilton, but lived most of her life in Cincinnati. She had been a practicing physician there for many years and formerly was district physician for the city. A niece and two nephews survive.

Louis John Wise, M.D., Cleveland; Starling Medical College, Columbus, 1901; aged 77; died May 31; former member of the Ohio State Medical Association, and recipient of the Association's 50-Year Award; former treasurer of the Summit County Medical Society. Dr. Wise began his practice in Akron and practiced there for many years before he moved to Cleveland in 1922. He was a member of the Catholic Church. Survivors include three daughters and a son.

Lincoln A. Yocum, M.D., Wooster; Marion-Sims College of Medicine, St. Louis, 1895; aged 89; died May 21; former member of the Ohio State Medical Association and the American Medical Association. Upon completion of his medical education, Dr. Yocum returned to Wooster where he had formerly lived and read medicine under the preceptorship of the late Dr. Joseph Todd. Dr. Yocum's service to the community as a physician was recognized in 1949 when he received the 50-Year Award of the State Association. He was for 21 years a member of the Board of Health and was one of the founders of the Wooster Hospital. Other affiliations included membership in the Lions Club and the United Presbyterian Church. He is survived by two daughters and a son.

AMA Again Will Cooperate with "Medical Horizons" Program

The American Medical Association will again cooperate with Ciba Pharmaceutical Products, Inc., next fall in a series of half-hour television programs. Arrangements have been completed for presentation of the popular "Medical Horizons" feature at 4:30 p.m., E. D. T., each Sunday over the American Broadcasting Company network, beginning Sunday, September 9.

"Medical Horizons" will originate live from hospitals, medical schools and research institutions throughout the country.

The new series will be seen on 85 stations, as compared with 42 stations which carried last year's programs. Don Goddard, veteran newscaster, will return as narrator.

Tornadoes in the United States took 1,766 lives during the decade 1946 through 1955, and inflicted injuries on approximately ten times that many persons, according to the Metropolitan Life Insurance Company's statisticians.

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*Modell, W.: The Relief of Symptoms, Philadelphia, W. B. Saunders Company, 1955, pp. 265-266.

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Washington Roundup . . .

News From Nation's Capital of Interest to Physicians; Reports of Developments in Medical and Health Fields; Activities of Agencies

The death of U.S. Senator Barkley of Kentucky has resulted in membership shifts on two committees important in health legislation. Senator Paul Douglas (D., Ill.), takes the Barkley post on the Finance Committee, which is responsible for all social security legislation and leaves the Labor and Public Welfare Committee which handles most other health bills.

* * *

The Veterans Administration is about to start a large-scale cooperative investigation of the value and usage of the new tranquilizing drugs in mental illness. The value of the different drugs in use and proper dosage for different types of patients will be studied. The resources of The National Research Council will be used.

* * *

The Army has announced the successful trial of a new respiratory disease vaccine which has reduced the incidence of hospitalized cases of respiratory disease among recruits by more than 80 per cent. The vaccine, which reaches its maximum effectiveness a week after administration, was developed and prepared at the Walter Reed Army Institute of Research.

* * *

Bills have been introduced in the House and Senate to place the Secretary of Health, Education, and Welfare in line of succession to the presidency. Because this department is the newest, the Secretary would rank last on the list.

* * *

The Hill-Burton hospital construction program, nearing its 10th anniversary is approaching 3,000 projects. As of April 30, approvals totaled 2,905, of which 2,035 were built and in operation, and 553 under construction. They provide for 131,061 hospital beds and 658 auxiliary units.

The Federal Trade Commission has reaffirmed its jurisdiction over interstate advertising of health and accident insurance, thus clearing the way for further action in its complaint against 36 companies charged with misleading advertising.

* * *

The Veterans Administration Department of Medicine and Surgery now has fee schedule arrangements with 25 State Medical Societies for outpatient care of beneficiaries. In nine other states, the agreement is made with the Blue Shield plan, which acts as an intermediary for billings and collections. In states with no agreement in force, the Catalog No. 5 Guide for Charges for Medical Services is used by VA field stations in making compensation for fee-basis medical care.

* * *

A recent directive by Secretary of Defense Charles E. Wilson gives the Navy Department control of procurement and distribution of all medical and dental supplies used by Army, Navy, Marine Corps and Air Force.

Health Commissioner Positions Are Available in Ohio

Officials of the Ohio Department of Health have requested *The Journal* to announce that several physician health commissioner positions are available in Ohio. Excellent salary ranges commensurate with the responsibilities are authorized for persons who qualify. Individuals interested in public health practices may secure information regarding locations and duties of such positions by contacting: Mr. E. A. Graber, Bureau of Local Services, Ohio Department of Health, 306 Ohio Departments Building, Columbus 15, Ohio; Phone CA 1-1265, Ext. 341.



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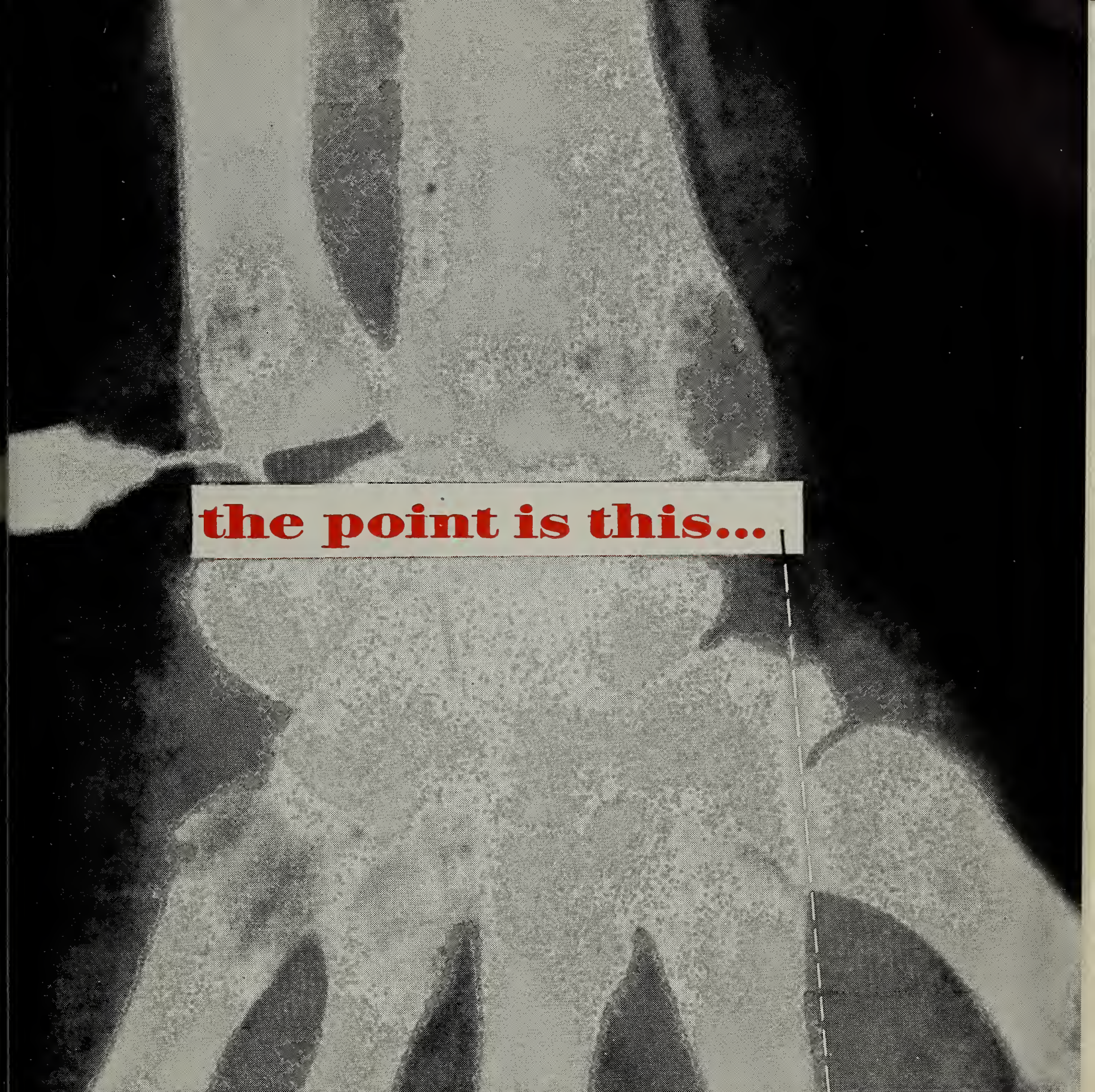
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References: 1. Hollander, J. L., Ann. New York Acad. Sc. **61**:511, May 27, 1955.

2. Hollander, J. L., et al. J.A.M.A. **158**:476, June 11, 1955.



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How Registered Nurses Should Renew License by Jan. 1, 1957

Any Ohio registered nurse who wishes to practice legally in Ohio as a registered nurse in 1957, is required by law to renew her certificate of registration by filing a renewal application and paying a fee of two dollars (\$2.00) by January 1, 1957.

Renewal blanks will be furnished by the Board and will be available about September 1, 1956. The fee should not be sent to the Board without being accompanied by the renewal blank.

A nurse who does not plan to practice nursing in Ohio as a registered nurse during the succeeding year is not required to renew her certificate, but may request to have her name placed on record as being inactive. This in no way voids her certificate of registration. She is not required to pay an annual renewal fee as long as she is not practicing in Ohio. Should she resume nursing in Ohio she may restore her registration to an active status by renewing her certificate and paying the renewal fee for the current renewal period only.

Any nurse who practices nursing in Ohio as a registered nurse after March 1, 1957, without holding a current certificate of registration, shall be regarded as an illegal practitioner of nursing.

Obstetrics-Gynecology Board Certifies 17 Ohioans

Seventeen Ohio physicians were certified recently by the American Board of Obstetrics and Gynecology, according to the official list forwarded by Dr. Robert L. Faulkner, Cleveland, secretary-treasurer. A total of 317 persons were certified throughout the nation. Applications are now being accepted for future certification.

Ohioans certified are the following: Drs. James A. Bowman, Jr., Cleveland; Simon W. Chiasson, Youngstown; Robert W. Colopy, Painesville; Arthur R. Fleming, Gallipolis; Francis W. Gallagher, Columbus; John M. Glenn, Cincinnati; Cyril V. Gross, Canton; Thomas H. Hoover, North Canton; Donald E. Hubbell, Cleveland; Zelig Katz, Dayton; Kalman C. Kunin, Youngstown; Milton Linden, Cleveland; Ernest L. Perri, Steubenville; James E. Printy, Sandusky; Robert M. Reineck, Toledo; Homer F. Schroeder, Toledo; Edwin R. Zartman, Columbus.

Ft. Steuben Academy

"Surgical lesions of Stomach and Duodenum" was the subject for the Fort Steuben Academy of Medicine program in Steubenville, April 10. Guest speaker was Dr. G. A. Hallenbeck, Department of Surgery, Mayo Clinic, Rochester, Minn. Local speaker was Dr. Howard Minor, of Steubenville. The dinner meeting was held at the Fort Steuben Hotel.

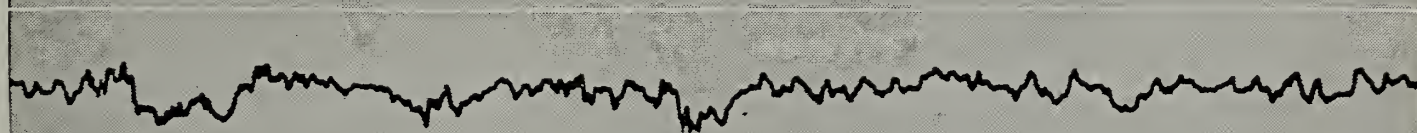
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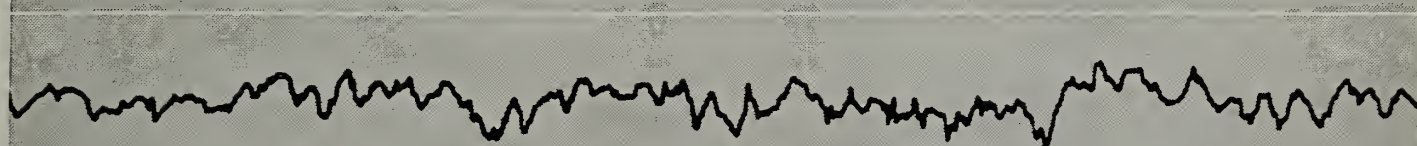
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WHAT IS THE DIFFERENCE BETWEEN A TRANQUILIZER AND A SEDATIVE?

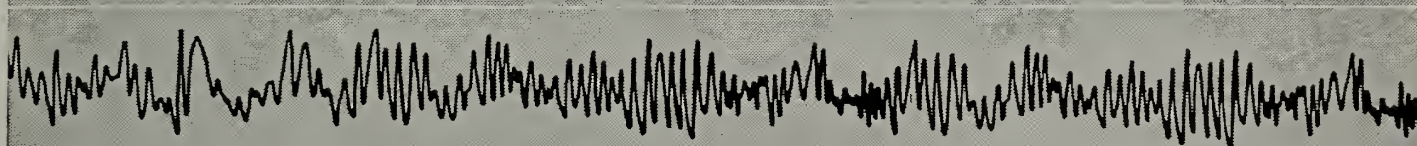
*Comparison of the effect of Raudixin (tranquilizer) and a
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No drug.



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Activities of County Societies . . .

First District

(COUNCILOR: CHARLES T. ATKINSON, M. D.,
MIDDLETOWN)

ADAMS

The Adams County Medical Society had its regular quarterly meeting Wednesday, May 16, at the Adams County Hospital. Only one member was absent, because of illness.

Dr. Woodyard, delegate to the recent convention of the Ohio State Medical Association in Cleveland, gave a concise report of the meeting.

Dr. Kenneth C. Jee, who came to Winchester in March, was made a member of the Society.

Dr. Bert H. McBride, neuro-surgeon, of Cincinnati, gave a talk on "Treatment of Head Injuries."

Those attending were Dr. Sam Clark, Cherry Fork; Drs. S. J. Ellison, S. B. Sonkin, Kurt Platschik, and Hazel L. Sproull, West Union; Dr. R. B. Ellison, Peebles; Dr. Alexander Salamon and Dr. R. L. Lawwill, Seaman; Dr. Kenneth C. Jee, Winchester; Dr. R. L. Woodyard, Manchester; and Dr. Bert H. McBride, Cincinnati, Ohio.—Hazel L. Sproull, M. D., Secretary.

CLERMONT

Dr. Julian E. Benjamin, of Cincinnati, spoke on the subject, "Modern Concepts in the Treatment of Heart Disease," at the June 20 meeting of the Clermont County Medical Society. Dr. Frank H. Lever was host at his home in Loveland.

HAMILTON

The Academy of Medicine of Cincinnati was co-sponsor of a Seminar on Venereal Disease on May 17 at the University of Cincinnati College of Medicine auditorium. Other sponsors were the College of Medicine, the Southwestern Ohio Society of General Physicians, the Cincinnati Dermatological Society, Cincinnati and Hamilton County Health Departments, Ohio Department of Health and the Cincinnati Social Hygiene Association.

The following physicians participated in the program: Dr. Charles Sebastian, president of the Academy of Medicine; Dr. Ira Schamberg, chief of the VD program of the Philadelphia Department of Health; Dr. Evan Thomas, consultant in VD, New York State Department of Health and emeritus professor of clinical medicine, New York University; Dr. Harold J. Magnuson, chief of the operational research section, VD program, U. S. Public Health Service; Dr. Alfred L. Weiner, assistant professor of dermatology and syphilology, University of Cincinnati, and director of the VD Clinic of Cincinnati General Hospital; Dr. Carl A. Wilzbach, Cincinnati health commissioner; and Dr. Frederick H. Wentworth, chief of

the Division of Communicable Diseases, Ohio Department of Health.

HIGHLAND

Dr. O. V. Rosenow, Columbus, was the guest speaker at the dinner meeting of the Highland County Medical Society on May 14 at Cowgill's Grill. A report also was made of the availability and use of polio vaccine as well as preliminary reports of the pre-school examination.

Second District

(COUNCILOR: G. A. WOODHOUSE, M. D.,
PLEASANT HILL)

CHAMPAIGN

The Champaign County Medical Society and the Auxiliary entertained members of the Logan County Medical Society and their wives with dinner at the Urbana Country Club early in May.

Special guests were Chauncey W. Leake, Ph. D., of Columbus, and Mrs. Leake, and Dr. Kurt C. Becker, of Troy, health commissioner. Dr. Leake, assistant dean of the Ohio State University College of Medicine, gave an interesting lecture on the life and works of Leonardo da Vinci. He illustrated his talk with slides of the subject's works of art.

CLARK

Pre-medical seniors and faculty advisers from Wittenberg College, Springfield, were guests of the Clark County Medical Society at a recent meeting. The speaker for the evening was Dr. Benjamin Felson, professor and director of radiology at the University of Cincinnati.

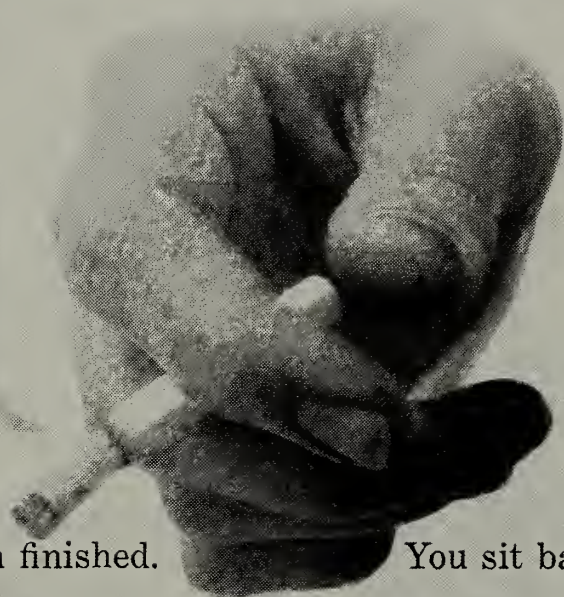
A panel composed of three speakers from Ohio State University was the feature of the May 21 meeting of the Society. The team was composed of Dr. Kenneth Abbott, assistant professor of neurosurgery; Dr. Francis McCoy, assistant professor of medicine; and Dr. Joseph Ryan, assistant professor of medicine (cardiology). The topic was "Neck, Shoulder and Arm Pain and Arm Paresthesia."

CLINTON

Dr. Drew Arnold, assistant professor of surgery at Ohio State University, Columbus, spoke at the luncheon meeting of the Clinton County Medical Society on May 1 in the General Denver Hotel, Wilmington. His subject was regional ileitis. Dr. Robert Conard, county health commissioner, reported on current morbidity in the county.

GREENE

Dr. Gordon E. Savage, Greene County health commissioner, reported on the county's polio inoculation program at the May 10 meeting of the Greene County Medical Society in Xenia. He



a pause for reflection . . . Operation finished. You sit back and relax. Blockain* anesthesia lasted long enough with one small injection so that you were easily able to proceed from incision to closure without pause for reinjection. **Longer anesthetic duration . . .** You did that accurate reapproximation of skin edges without distortion from freshly introduced anesthetic. And more, Blockain persisted post op.—you had no complaints of uncomfortable splints, dressings or tender tissues. **Rapid onset, too . . .** You recall that the pre-incision wait was avoided. *A case to remember:* A 78-year-old patient, arteriosclerotic, poor liver function with a transcervical fracture of left femur, underwent a *one-hour-and-20-minute operation*, involving internal fixation of the fracture and the placement of a Smith-Petersen nail, with *one injection of Blockain*. Effect of anesthetic: “excellent.” Onset of anesthesia: “rapid.” Only 60 cc. of Blockain was used. A whiff of nitrous oxide was given at the time of actual hammering, to spare the patient emotional trauma. There were no side effects. **BLOCKAIN**, 30 cc., 0.5% (5 mg./cc.). Write GEORGE A. **Breon** & CO., 1450 Broadway, N. Y. 18 for additional information.

reported that more than 20,000 individual inoculations had been given. Dr. Charlotte Ames presided at the meeting at which 27 physicians were present.

Mr. Karl F. McKay, representative of the Eli Lilly Company, showed a film, illustrating the processes in production of Salk vaccine.

MONTGOMERY

The General Practice Section and the Montgomery County Chapter of the Ohio Academy of General Practice met on May 16 at Suttmiller's Restaurant for luncheon and a program. Speaker was Dr. James C. Burt, whose topic was, "Anesthesia and Analgesia in Labor and Delivery."

Third District

(COUNCILOR: JAMES R. JARVIS, M. D., VAN WERT)

CRAWFORD

The Crawford County Medical Society met for the May session at the American Legion Home in New Washington. Dr. F. J. Herringhaus, of Mansfield, spoke on the subject, "What's New in Medicine." William Beer, Bucyrus attorney, and Civil Defense administrator, also spoke to the group.

Fourth District

(COUNCILOR: PAUL F. ORR, M. D., PERRYSBURG)

LUCAS

The following features were part of the program of the Academy of Medicine of Toledo during May:

General Meeting, May 4—"Investments," a talk by Philip P. Brooks, Jr., assistant vice-president of the Ohio Citizens Trust Company of Toledo.

May 10, Postgraduate Lectures on "Medical Management of Disaster," by the U. S. Army Medical Corps personnel.

Medical Section, May 18—"Advances in the Treatment of Diabetes," Dr. Max Miller, associate professor of medicine, Western Reserve. Dr. Miller discussed the use of Fructose in diabetic acidosis and stress states, and the value of oral Tolyl-sulfonyl-butyl urea (Orinase) as an insulin substitute.

Surgical Section, May 25—"Hiatus Hernia," Dr. Philip Thorek, associate professor of surgery, Cook County Graduate School of Medicine, Chicago.

Inter-Hospital Postgraduate Lecture Series, May 10—Two panel discussion periods were held in the afternoon and evening. This program was presented by the Medical Advancement Trust of the Maumee Valley Hospital and the Trauma Committee of the Toledo Chapter, American College of Surgeons.

The subject of discussion was "Medical Management of Disaster," and to present it a team from the U. S. Army Medical Corps was present. The team included Colonel Clinton S. Maupin,



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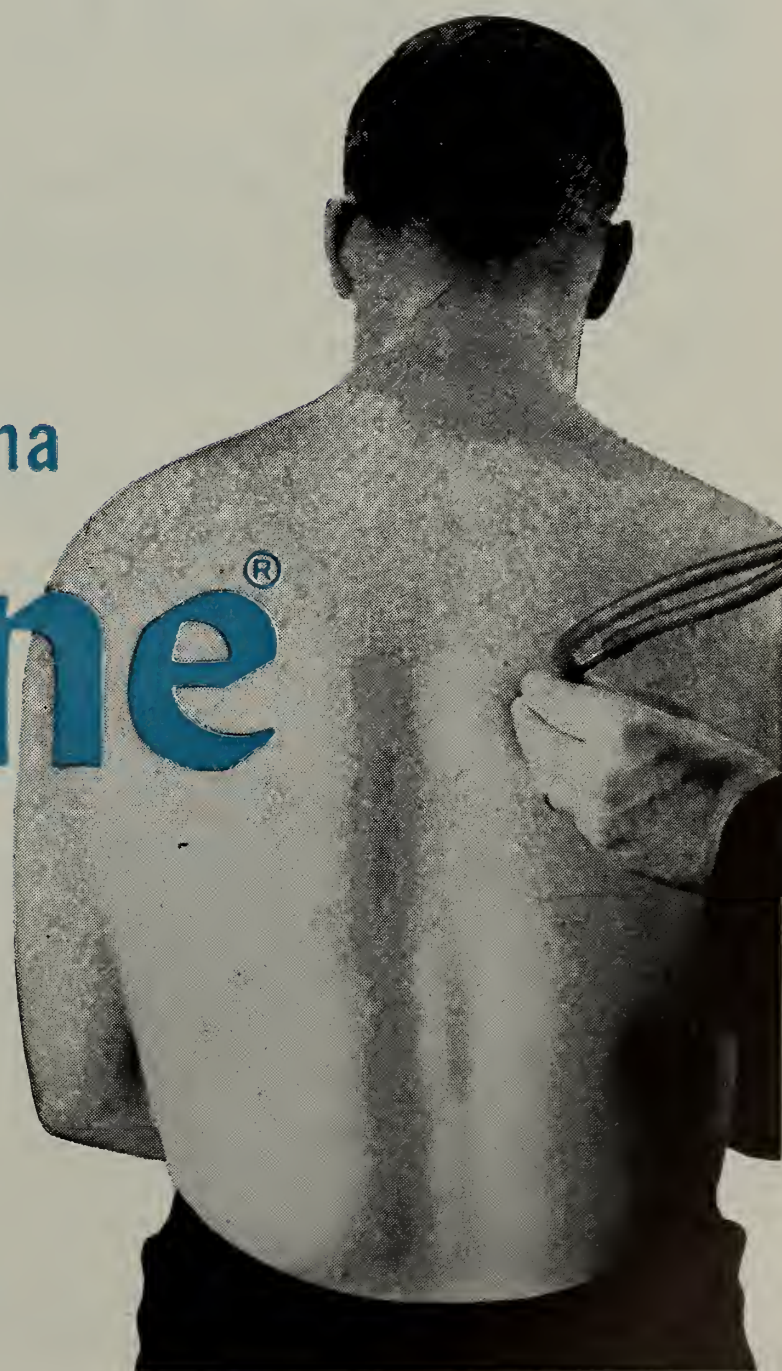
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1. Johnston, T. G., and Cazort, A. G.:
J. Allergy 27:90, 1956. 2. Schwartz, E.:
New York J. Med. 56:570, 1956.
3. Schiller, I. W., et al.: J. Allergy
27:96, 1956.

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special assistant to the SGO for Nuclear Energy; Lt. Colonel Arthur Steer, Walter Reed Medical Center; Lt. Colonel Joseph D. Goldstein, Walter Reed; Colonel Joseph R. Shaeffer, chief surgical consultant in the office of the Surgeon General, Washington, D. C., and Colonel Albert J. Glass, chief of the Department of Neuropsychiatry, Walter Reed.

Sixth District

(COUNCILOR: CARL A. GUSTAFSON, M. D.,
YOUNGSTOWN)

COLUMBIANA

Dr. William Donaldson, of Pittsburgh, discussed "Orthopedic and Pediatric Problems," for the Columbiana County Medical Society on May 15 at the Wick Hotel in Lisbon, following a joint dinner with the Auxiliary.

PORTAGE

On May 22 the Portage County Medical Society met at Robinson Memorial Hospital to hear an interesting lecture, illustrated by numerous slides, by Dr. Lester Adelson, pathologist, chief deputy coroner of Cuyahoga County, and assistant professor of legal medicine in the Department of Pathology, Western Reserve University School of Medicine, Cleveland. Dr. Adelson spoke on "The Role of the Pathologist in Homicide Investigation." Twenty-one members of the Medical Society were present. The Portage County Bar Association had been invited to this meeting and seven members of that Association were present. Refreshments were served following the meeting.—Arthur L. Knight, M. D., Secretary-Treasurer.

STARK

The Stark County Medical Society held its annual outing and dinner at the Congress Lake Club on May 23 with approximately 200 attending. Golf was played in the afternoon. After dinner Dr. George M. Wilcoxon, president, conducted a brief session and presented golf awards.

SUMMIT

The Summit County Medical Society had as guest speaker on June 5, Dr. Frederic N. Silverman, associate professor of radiology and pediatrics, at the University of Cincinnati, and director of the Division of Roentgenology, at Cincinnati Children's Hospital. His subject was "Unrecognized Trauma in Infants and Children."

The meeting in the Akron General Hospital auditorium was preceded by dinner at the Akron City Club.

Eighth District

(COUNCILOR: WILLIAM D. MONGER, M. D.,
LANCASTER)

ATHENS

Dr. Walter Freeman described results of transorbital lobotomies performed at the Athens

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*Moyer, J. H., and others:

J. Chronic Dis. 2:670, 1955.

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State Hospital before a meeting of the Athens County Medical Society on May 7. It was Dr. Freeman's sixth visit to the hospital where he was guest of Dr. H. H. Fockler, hospital superintendent. Dr. Freeman is former professor of neurology and neurological surgery at George Washington University and is now residing in Los Altos, Calif.

MUSKINGUM

Dr. Oren I. Dustheimer was honored by the Muskingum County Medical Society on June 5 with a dinner at the Zanesville Country Club. Dr. Robert S. Martin, Zanesville, President-Elect of the Ohio State Medical Association, presented Dr. Dustheimer with the 50-Year Pin and Certificate of the Association.

Dr. Dustheimer received his medical degree from Ohio Medical University, Columbus. Most of his medical career has been in Zanesville where he moved early after practicing for a while at nearby Sonora.

Ninth District

(COUNCILOR: C. L. PITCHER, M. D., PORTSMOUTH)

SCIOTO

"Pitfalls in Management of Refractory Heart Failure," was the subject of the scientific program at the June 11 meeting of the Scioto County Medical Society in Portsmouth. The presentation was in the form of a film prepared by the Georgetown University Medical School and the American College of Physicians.

Eleventh District

(COUNCILOR: H. T. PEASE, M. D., WADSWORTH)

ASHLAND

Honor for a half century of service in the medical profession was bestowed on Dr. George Riebel at a special dinner meeting of the Ashland County Medical Society at the Ashland Country Club on May 4.

Several persons took part in the special program, among them Dr. C. B. Meuser, county health commissioner, who described the pioneer work of Dr. Riebel in bringing many of the latest developments in medicine to the community. Judge Hugh Culbertson represented both the legal profession and the hospital board at the dinner. Dr. Howard R. Wetzel served as toastmaster.

Highlight of the occasion was presentation of the 50-Year Award of the Ohio State Medical Association to Dr. Riebel by Dr. H. T. Pease, Wadsworth, Eleventh District Councilor.

The dinner was arranged by a committee composed of Drs. H. V. Maley, A. D. Robertson, William Rower and R. Lee Schafer.

MEDINA

The Medina County Medical Society held its regular monthly meeting at the Medina Com-



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munity Hospital on May 17. The speaker for this meeting was Dr. Uffe Jensen, Akron, who discussed "The Diagnosis of Congenital Cardiac Anomalies in the Cardio-Pulmonary Laboratory."

After the meeting the physicians were guests at dinner of the Medina Community Hospital Board of Trustees.—W. G. Halley, M. D., Secretary.

RICHLAND

The regular monthly meeting of the Richland County Medical Society was held at Mansfield General Hospital, May 10. Dinner was served at the hospital, after which Dr. P. O. Staker, president, conducted a brief business meeting.

The speaker of the evening was C. E. Rupe, M. D., Physician-in-Charge of the Fourth Medical Clinic at Henry Ford Hospital in Detroit, Michigan. His subject was: "Diseases of Therapy."—C. F. Curtiss, M. D., Secretary.

WAYNE

The Wayne County Medical Society held its monthly meeting at Dunlap Hospital in Orrville on May 9 with more than 60 in attendance.

Clark C. Grubbs, assistant chief deputy claims administrator of the Bureau of Workmen's Compensation, Columbus, spoke describing the procedure for processing claims through the Bureau. Physicians' assistants and hospital personnel were guests at the meeting. Dr. H. J. Pease, Wadsworth, Eleventh District Councilor, was present. Dr. Edwin J. Feltes, president of the Society, presided.

Tighter Narcotics Penalties Urged By Congressional Committees

Two committees of Congress, after long studies of problems of narcotics, barbiturate and amphetamine addiction, have come up with recommendations that the U. S. tighten penalties on narcotics peddling and smuggling, outlaw heroin and set up a central unit in the Federal Bureau of Narcotics to keep track of known addicts. The proposals were made by the Senate Judiciary committee and a House Ways and Means subcommittee. The House committee also suggested a law for more stringent controls over barbiturates and amphetamines. The Senate committee rejected the proposal backed by the New York Academy of Medicine for "clinics" where known addicts could go for regular doses of narcotics.

Dr. B. Dixon Holland, who is retiring soon as Colonel in the U. S. Army Medical Corps, has been appointed by the AMA Board of Trustees as secretary of the AMA Council on Industrial Health. He will fill the post left vacant by the death of Dr. Carl M. Peterson.

Dr. Clarence W. Engler, Cleveland, was elected president of the Broncho-Esophagological Association at its recent convention in Montreal.

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1. Fazekas, J.F., et al.: J.A.M.A. 161:46 (May 5) 1956. 2. Mitchell, E.H.: J.A.M.A. 161:44 (May 5) 1956.

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2—Mrs. W. R. Gibson, Oak Harbor
3—Mrs. C. A. Colombi, Cleveland

Recording Secretary—Mrs. Lester W. Sontag, Livermore St.,
Yellow Springs

Corresponding Secretary—Mrs. Earl Young, 170 Brookline
Ave., Youngstown

Past-President and Finance Chairman—Mrs. Karl Ritter,
1420 Shawnee Rd., Lima

Chairman Publicity Committee—Mrs. Carl F. Goll

AUGLAIZE

The March meeting of the Auglaize County Medical Auxiliary was held in the home of Mrs. G. L. Miles, with Mrs. E. E. White as co-hostess. The ladies enjoyed playing benefit bingo. Money collected was given to Miss Lillian Stoll, hospital administrator, to be used at Memorial Hospital where needed.

The newly elected officers are as follows: Mrs. J. Romaker, Cridersville, President; Mrs. R. Herrman, Wapakoneta, vice-president; Mrs. D. Nielson, Waynesfield, secretary-treasurer.

ERIE

Milan Inn was the setting for the regular monthly luncheon meeting of the Medical Auxiliary. Hostesses who planned the affair were Mrs. E. J. Meckstroth, Mrs. Paul Vasquez and Mrs. R. E. Taylor.

Mrs. W. C. Seiler and Mrs. C. R. Swanbeck were named as delegates to the State Convention.

A book, "Nursing Practice and the Law," was added to the School of Nursing library at Providence Hospital as a memorial to the late Mrs. H. C. Schoepfle. Members voted to make a contribution to the Presbyterian Church building fund in memory of the late Mrs. C. B. Bliss who also was an honorary member of the Auxiliary.

HAMILTON

An instrumental and vocal trio composed of members of the faculty of Xavier University, provided the entertainment for the meeting of the Woman's Auxiliary to the Hamilton County Medical Society on March 20.

A dessert, preceding the meeting, was served in the Gallery of Musical Instruments in the Cincinnati Art Museum at noon. The day's hospitality chairman was Mrs. Edward J. Bender, and she was assisted by Mrs. Jerome N. Janson.

Mrs. Joseph H. Goldcamp, program chairman for the day, presented the guests, and Mrs. Herbert J. Brinker, president of the Auxiliary, presided at the business meeting following the program.

HARDIN

The monthly dinner meeting of the Hardin County Medical Society Auxiliary was held in

the dining room at San Antonio Hospital with 15 members present.

In the absence of the president, Mrs. Robert Schultz, who was attending the annual Auxiliary convention in Cleveland, Mrs. L. A. Black was in charge of the business session.

The following new officers were elected at this time: President, Mrs. Floyd Elliott, of Ada; vice-president, Mrs. R. A. Dietrich, of LaRue; secretary, Mrs. W. P. Drake, of Richwood; treasurer, Mrs. W. F. Binkley, of Kenton.

During the meeting the Auxiliary made provision for their donations to the annual Hospital Day to be held in July for Hardin Memorial Hospital and the Lawn Fete for San Antonio hospital in August.

Sister Theodore gave a most interesting report on hospital management and operating expenses.

HURON

The Woman's Auxiliary to the Huron County Medical Society met on April 13 in the home of Mrs. Walter Drury in Willard. Mrs. John Emery served as assistant hostess.

Mrs. Alice Rinderle was the guest speaker for the meeting. She gave a most interesting talk on needs and accomplishments of handicapped children.

JEFFERSON

The Jefferson County Medical Society and Woman's Auxiliary held a joint meeting on March 22. Dr. and Mrs. Warren Snyder, of Sharmont Manor, Steubenville, were the host and hostess. After separate business meetings, a social hour was enjoyed.

LUCAS

Dr. Walter C. Alvarez, editor-in-chief of the *Modern Medicine* magazine spoke at an open meeting of the Woman's Auxiliary to the Academy of Medicine of Toledo and Lucas County on March 20. A short business session was held prior to the talk. Mrs. W. Leroy Bryant is program chairman, and Mrs. John Buck, Mrs. B. V. Schieb and Mrs. M. R. McGarvey were hostess chairmen.

FAIRFIELD

One hundred and four junior and senior girls representing 13 high schools in Fairfield County were guests at the annual Future Nurses Tea given by the Woman's Auxiliary to the Fairfield County Medical Society. The event was held Friday, April sixth, in the Nurses' Home of Lancaster Fairfield Hospital.

Mrs. Charles F. Clark was general chairman for the tea. She was assisted by these special chairmen: Mrs. C. R. Reed, Mrs. F. A. Dowdy,

Mrs. S. C. Sneering, Mrs. J. L. Kraker and Mrs. Stephen R. Hodsden.

LORAIN

Representing 21 high schools in Lorain County, 125 senior girls were guests of the Woman's Auxiliary to the Lorain County Medical Society on April 19. The annual nurse recruitment tea was held at the Spring Valley Country Club with Mrs. Franz Gruen in charge.

MAHONING

Mrs. Paul J. Mahar, Youngstown, is the new president of the Mahoning County Medical Society's Woman's Auxiliary, having been elected at the April meeting. Mrs. Carey S. Peabody is the new president-elect.

Mrs. Craig C. Wales, retiring president, presided and Mrs. David R. Brody, chairman for the day, introduced Dr. Fred L. Schellhase who gave a talk on civil defense. Mr. Lew Reed, of the Youngstown-Mahoning Red Cross, presented certificates to 11 members of the Auxiliary who have completed the third first aid program.

Mrs. Mahar's associate officers during the coming year will be Mrs. Earl H. Young, vice-president, Mrs. Arthur Rappoport, recording secretary; Mrs. Elmer H. Nagel, corresponding secretary; Mrs. Sidney Franklin, treasurer.

MIAMI

Members of the Woman's Auxiliary of the Miami County Medical Society met for a tea and installation of officers on April 3 at the home of Mrs. Burton Hogle, of Troy.

Mrs. B. E. Hyde, retiring president, installed new officers as follows: President, Mrs. E. G. Puterbaugh, Tipp City; president-elect, Mrs. Dean Armour, Bradford; vice-president, Mrs. C. E. Stout, West Milton; treasurer, Mrs. Jerry Hammon, West Milton; secretary, Mrs. Burton Hogle, Troy.

Mrs. Lester Sontag of Yellow Springs, district chairman of Ohio State Auxiliary, was a guest.

RICHLAND

Mrs. Paul Lee, program chairman of the Woman's Auxiliary to the Richland County Medical Society, introduced Miss Harriett Wain who gave a recitation entitled, "The Doctor," for the program when members met April 2 for luncheon at the Women's Club.

Miss Wain also read one of her own original compositions, entitled "The Doctor's Wife." Mrs. Lee entertained members with a poetic pantomime on civil defense. Others participating in the pantomime were Mrs. Harry Wain and Mrs. Wendell Bell.

A short business session, conducted by the president, Mrs. Robert Peirce, preceded the program. Hostesses for the meeting were Mrs. C.

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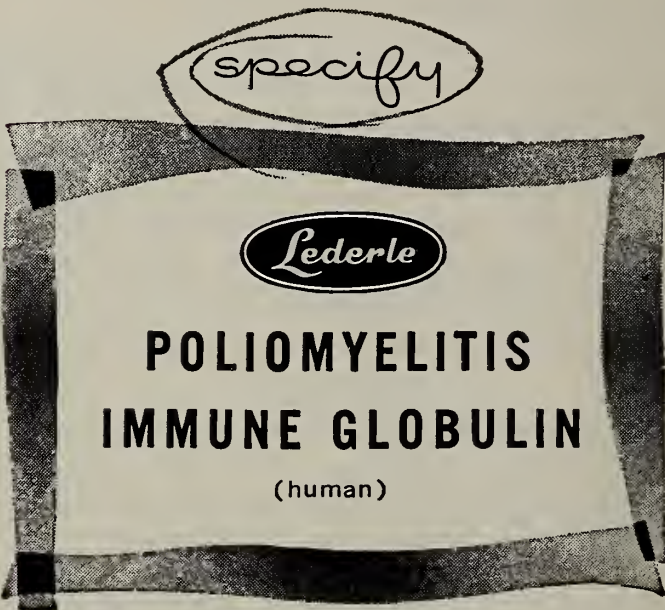
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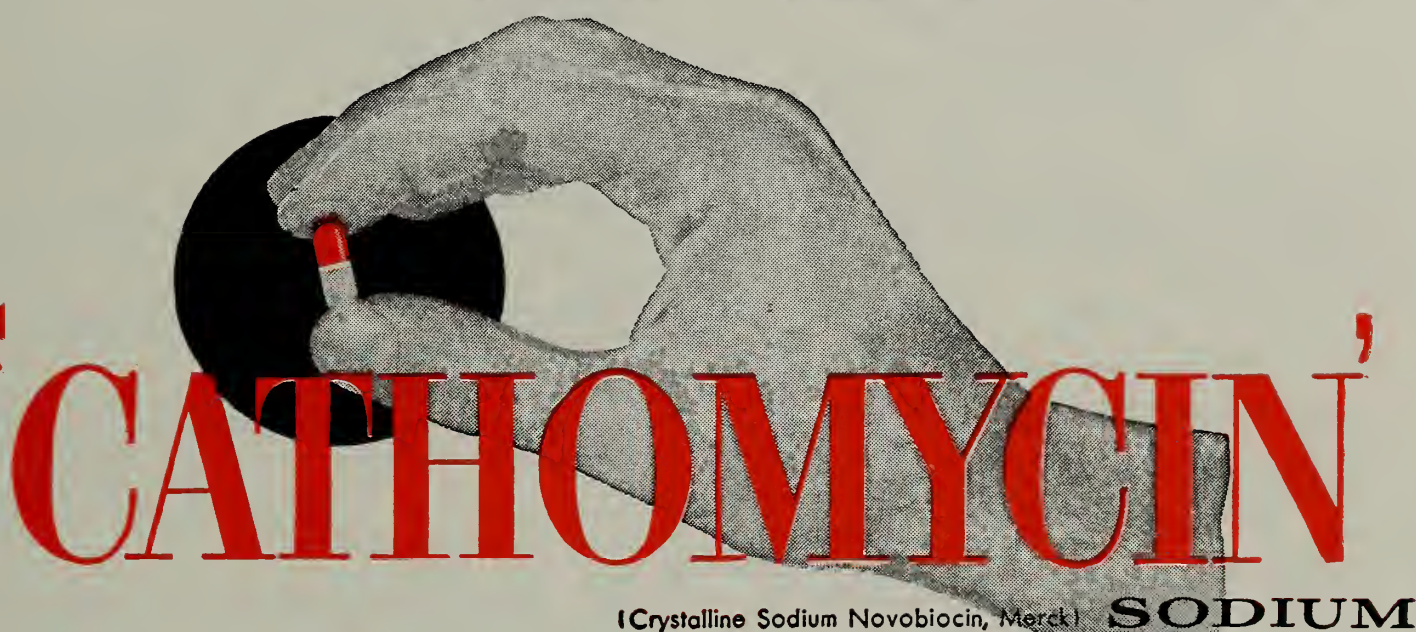
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VAN WERT

The Van Wert County Medical Auxiliary had its April meeting in Fort Wayne and featured a guided tour of Parkview Memorial Hospital. The hospital Medical Staff Auxiliary recently purchased a bottle warmer for the hospital nursery from the Baby Auxiliary Fund.

The new officers for the Auxiliary are as follows: Mrs. Edwin Burnes, President; Mrs. A. C. Diller, vice-president, and Mrs. Norman Marxen, secretary-treasurer.

WASHINGTON

Dr. Robert Fischer, of Marietta College, spoke to members of the Woman's Auxiliary to the Washington County Medical Society on April 4 following a luncheon at Hotel Lafayette. His topic was "New Techniques in the Psychological Treatment of Children and Adults."

Mrs. Donald Fleming, president, reported on the new officers for the coming year. Mrs. Clarence Ash, is the new president with Mrs. David Thornburgh, vice-president, and Mrs. Donald Williams, secretary-treasurer. Mrs. Fleming and Mrs. Ash were delegates to State Convention in Cleveland.

Doctors Representing 41 Nations Are Entertained in Cincinnati

Cincinnati's international reputation as a medical training center was highlighted in May when more than 100 interns and resident doctors from 41 different countries were entertained by The Wm. S. Merrell Company and the Midwest International Trade Development Center.

One of the principals in the program was Dr. Charles A. Sebastian, president of the Cincinnati Academy of Medicine. The guest list included 42 Europeans. Africa and the Near East had 13 representatives, Latin America 19, Canada and Puerto Rico 12, and the Far East 25. The physicians were completing their studies at 12 Cincinnati hospitals.

Dr. Donald B. Glover, Cleveland, clinical professor of surgery at Western Reserve University, was elected president of the American Association for Cleft Palate Rehabilitation which met in Kansas City.

INDEX TO ADVERTISERS

American Meat Institute	690
Ann Arbor School	777
Appalachian Hall	786
Ayerst Laboratories, Inc.	768
Bayer Company, The, Div. of Sterling Drug Co., Inc.	702
Breon, George A., & Co.	771
Burroughs Wellcome & Co. (U. S. A.) Inc.	703
Ciba Pharmaceutical Products, Inc.	784
Cincinnati Sanitarium	696
Cook County Graduate School of Medicine	780
Davies, Rose & Co., Ltd.	776
Endo Products, Inc.	704
Flint, Eaton & Company	697
Foot-so-Port Shoe Company	774
Geigy Pharmaceuticals, Inc.	775
General Electric Co.	783
General Foods Corporation (Sanka)	692
Harding Sanitarium	701
Hoffmann-LaRoche, Inc.	Insert between pages 700 - 701
Lakeside Laboratories, Inc.	685, 765, 774
Lederle Laboratories	740 - 741, 780
Lilly, Eli, and Company	708
Luzier's, Inc.	788
Magnetic Springs Foundation	791
Mallard, Inc.	772
McMillen Sanitarium	701
Medical Protective Company	765
Neil Training School	783
New York Polyclinic Medical School	784
Parke, Davis & Company	792 and Inside Back Cover
Pfizer, Chas. & Co., Inc.	763, 773
Picker X-Ray Corporation	705
Pogue, Mary, School, Inc.	788
Rocky Glen Sanatorium	788
Sawyer Sanatorium	700
Schering Corporation	689, 706 - 707, and Insert Between Pages 776 - 777
Scroggins, Clayton L., Associates (Medical-Dental Management)	691
Searle, G. D. & Company	759
Sharp & Dohme, Inc. ..	693, 694-695, 767, 781, 785, 789
Smith, Kline & French Laboratories	687, and Back Cover
Squibb, E. R. & Sons, Division of Olin-Mathieson Chemical Corporation	769
Tutag, S. J. & Company	786
Wallace Laboratories	787
Wendt-Bristol Company	777
Wickhaven Sanitarium	782
Windsor Hospital, Inc.	766
Winthrop Laboratories	790
Wyeth, Inc.	691, 778

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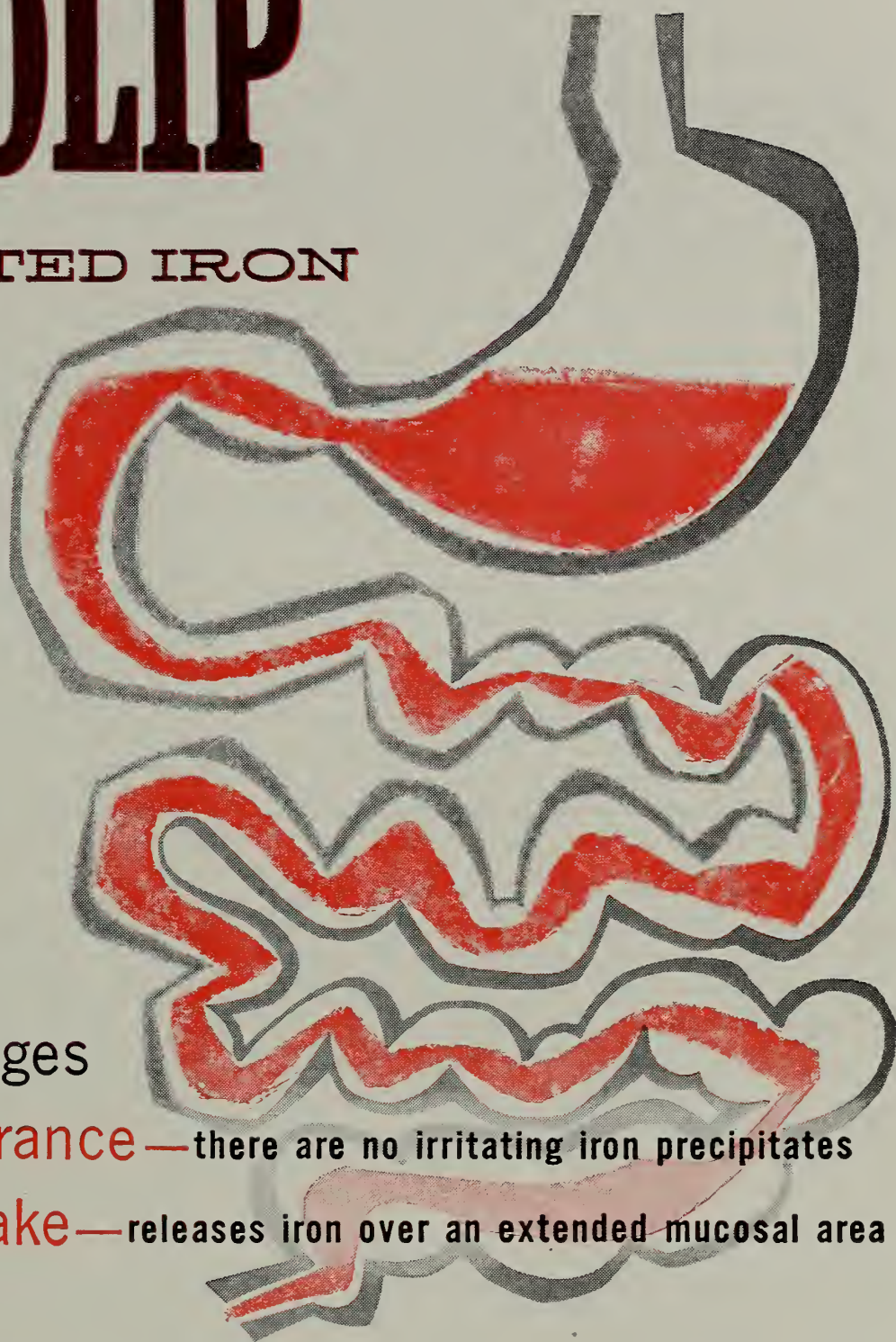
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The Physician's Bookshelf

By JONATHAN FORMAN, M. D.

Atomic Energy Research at Harwell, by K. E. B. Jay, (\$4.75. *Philosophical Library, New York, N. Y.*). This book from the United Kingdom Atomic Energy Authority describes the work done from 1951 to 1954, with much material which was secret before that time.

Dear Doctor, by Juliet Lowell, (\$1.95. *M. S. Mill Company, Inc., 425 Fourth Ave., New York 16, N. Y.*). This is an interesting series of letters received by well-known physicians who know that the uninhibited laugh helps in healing and preserves sanity in these strange times. It is a book that every doctor will get many a laugh from.

Understanding Surgery, by Robert E. Rothenberg, M. D., New York University, (\$.50. *Pocket Books Inc., New York, N. Y.*) In his own practice the author stresses the importance of patient's understanding of the emotional reactions to surgery. With the aid of seven other specialists he has prepared a text which clearly explains the nature of surgical operations and the reasons for them.

My Hospital in the Hills, by Gordon S. Seagrave, M. D., (\$3.75. *W. W. Norton & Co., New York, N. Y.*). This is a new book by the author of *Burma Surgeon*, and tells the exciting story of what has happened to him since he returned to his bombed-out hospital at Namkham after the war.

The Biology of the Spirit, by Edmund W. Sinnott, (\$3.50. *Viking Press, New York 17, N. Y.*). In this book the Dean of the Graduate School of Yale University examines the biological evidence for the existence of the human spirit. Using deductions from the findings of the biological laboratory, the Dean has evolved an absorbing thesis, in which human aspirations and the reality of the spirit of man are found imbedded in the properties of protoplasm.

The Mechanisms of Healing in Human Wounds, by Shattuck Hartwell, M. D., (\$4.75. *C. C. Thomas, Pub., Springfield, Illinois*). One of the Bannerstone lectures in surgery, this book attempts the correlation of the clinical and the tissue factors involved in the healing of human surgical wounds, burns, ulcers, and donor sites.

Denial of Illness, by Edwin A. Weinstein, M. D., and Robert L. Kahn, Ph. D., (\$4.75. *C. C. Thomas, Pub., Springfield, Ill.*). Mount Sinai Hospital, New York City, is the site of this monograph which represents the culmination of eight years of intensive investigation of behavior changes in brain tissue, using a combined neurological, psychological and psychical approach. As a result,

a unifying theory has been developed which takes into account many of the seemingly disparate phenomena. It also describes methods for examining the so-called confusional states as they occur in structural brain damage, after the administration of drugs such as barbiturates and alcohol, and after hormonal agents such as cortisone.

Swift and Carroll, A Psychological, Analytical Study of Two Lives, by Phyllis Greenacre, M. D., (\$5.00. *International Universities' Press, 227 W. 13th St., New York, N. Y.*). The author with infinite care and thoroughness has examined the lives and characters of these two authors, and related them to the themes and characters of their writings, by which Gulliver and Alice have become immortals. She concludes that there is an intrinsic likeness which exists in all opposites, and she also succeeds in offering an explanation of the universal appeal of these two classical characters.

Sexual Precocity, by Hugh Jolly, M. D., (\$6.75. *Charles C. Thomas, Pub., Springfield, Ill.*). This book, No. 200 in the American Lectures Series, is a personal study of 69 patients by the eminent British pediatrician. It presents a wealth of data of importance to the endocrinologist and to the student interested in the subject. It fulfills a real need by shedding additional light on the problems of the various types of sexual precocity and on the methods of differential diagnosis. The first half of the book is a critical review of the whole subject, and the second half is devoted to individual case reports from the author's own practice.

Surgery in World War II: Hand Surgery, edited by Sterling Bunnell, M. D., (\$3.75. *Office of the Surgeon General, Department of the Army, Washington 25, D. C.*). In the history of the preceding wars, scant attention has been paid to this important topic. Profiting by experiences in the first World War, many surgeons began to devote increased attention to improving upon existing methods for the post-traumatic care of the hand. So great did this interest become that a number of "hand centers" grew up after World War II in the United States and in Europe. The result of the treatment of hand wounds and the methods of treatment and care in these centers are quite completely presented in this volume.

The Science Book of the Human Body, by Edith E. Sproul, M. D., (\$4.95. *Franklin Watts, Inc., New York 25, N. Y.*). The Associate Professor of Pathology at Columbia University, with the help of Cathleen Elgin, an illustrator, has here

presented a study easily read by the layman, yet one which is a simple, up-to-date introduction to a complex subject. Comprehension is made easier by the many pictures and diagrams.

Cancer of the Lip, With Special Reference to the Predisposing Influences of Sunlight and Other Climatic Factors, by Martti Johannes Hamalainen, Helsinki. (Supplement No. 6 to Volume 440 of the *Annales Chirurgiae et Gynaecologiae Fenniae*, 17 Yrjonkatu, Helsinki, Finland). The object of this investigation was the disease "cherlitis erfaliativa actinica chronica" which is caused by climatic factors. Of 218 patients of the Lukoplakia, Chronic Ulcer and Cherlitis group, 84 patients (38.5 per cent) had erfoliation. Of the 452 patients of the cancer group, 187 patients (41.4 per cent) had actinica foliation.

Family Meals and Hospitality, by Dora S. Lewis, Gladys Citek Peckham, and Helen Stone Hovey, (\$3.88. Revised edition, *Macmillan Company, New York, N. Y.*). This book is designed to help young people acquire competence in planning, marketing, and serving foods. Scorning satisfaction with anything less than excellent cuisine, the authors underline good management, getting the most for your money, dovetailing jobs, and planning everything so that the homemaker can make mealtimes relaxing and pleasurable for everyone.

Translations of the Beltone Institute on Occupational Deafness From White Noise, edited by Charles Lightfoot, Ph. D. (Apply *Beltone Institute for Hearing, Chicago 32, Illinois*). Noisy machines have made "deafness caused by noise" among the diseases insured as accidents on the job, and have made these studies of great interest. This book is concerned with injuries caused to the human ear by the noises of the "Larderello" borax wells in Tuscany, Italy.

Are Men Equal?—An Inquiry Into the Meaning of American Democracy, by Henry Alonzo Myers, M. D., (\$1.45. A Great Seal Book, *Cornell University Press, Ithaca, N. Y.*). This is an attempt to find the roots of the doctrine of equality. The author rejects the doctrine of natural equality based on *a priori* views of nature. "But Nature has not furnished us with a list of private rights suitable to all times and all places." Myers says the proposition of equality is based on common events in the lives of human beings. Whenever one man sees another as he sees himself, or whenever men share joys and sorrows, it is confirmed. "One being of infinite worth cannot be greater or less than another being of infinite worth."

A Doctor's Book of Hours, by Merrill Moore, M. D., (\$6.00. *Charles C. Thomas, Publr., Springfield, Ill.*). Some have called him the Oliver Wendell Holmes of the twentieth century. As a Boston physician who practices 40 hours a week

of medicine and in his spare time has written a vast amount of sonnets, Dr. Moore has made contributions not only to literature but also to history and sociology.

Poet and Psychiatrist; Merrill Moore, M. D., by Henry W. Wells, (\$5.00. *Twayne Publishers, 31 Union Square, West, New York 3, N. Y.*). Moore is perhaps best known as the author of an incredible number of sonnets. His striking achievement in other fields of endeavor was the cause of this study, "The Mental Measure" of Merrill Moore, presented frankly as a study of genius.

Stuttering in Children and Adults, 30 Years of Research at the University of Iowa, by Wendell Johnson, M. D., and Ralph R. Leutenegger, M. D., (\$5.00. *University of Minnesota Press, Minneapolis 14, Minn.*). There are estimated to be, among our handicapped people, 15 million persons who stutter. The studies collected in this volume represent a substantial contribution. This book presents all the previously unpublished papers and dissertations from the University—some 43 in all. It is an important book for psychologists, educators, social workers, parents, and physicians.

Variations in Sexual Behavior, a Psychodynamic Study of Deviations in Expression, by Frank S. Caprio, M. D., (\$5.00. *The Citadel Press, New York, N. Y.*). The author of this book is consultant to the Department of Correction, Washington, D. C. His previous book with Dr. Louis S. London on *Sexual Deviations* was held as the most important study since Craft-Ebing's *Psychopathia Sexualis*. Since the appearance of that book, the author has continued his clinical researches into the subject. His findings, carefully edited and illustrated with case histories, are set forth in this book.

The Doctor and the Soul: An Introduction to Logotherapy, by Viktor E. Frankl, M. D., translated from the German by R. & C. Winston, (\$4.00. *Alfred A. Knopf, New York 22, N. Y.*). In this book the author, a Viennese psychiatrist, sets forth the principles of a school of psychiatry which has been gaining acceptance since the last war. It is the author's chief aim to redress the balance between man's neglected spiritual values and his basically materialistic drives, by emphasizing the existence of man's soul and developing a scientific approach (known as existential analysis) for administering to his frustrations.

Polio Pioneers, by Dorothy and Philip Sterling, (\$2.75. *Doubleday & Company, Garden City, New York*), is the story of all the things that had to be discovered about disease, vaccinations, lens, microscope, bacteria, viruses and how to grow them. The illustrations are beautiful and effective. The text is an excellent example of good communications.



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Vol. 52

August, 1956

No. 8

JONATHAN FORMAN, M. D., *Editor*

CHARLES S. NELSON,
Managing Editor—Bus. Mgr.

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Asst. Managing Editor

Toward Understanding the Adolescent Drug User

WILLIAM E. TODD, M. D., and ROSS M. BLEAK, M. D.

I. INTRODUCTION

IN the winter and spring of 1951 it became apparent that there was an increasing number of drug users among the population at a federal reformatory for boys (ages 16 to 24).

A survey in the spring of 1951 indicated 70 out of 1,100 or 6.4 per cent had a history of drug usage including heroin, marijuana, barbiturates, benzedrine, cocaine and morphine. By far the largest group used heroin. Twenty-five per cent of the Negro population had used some drugs; 15 per cent of them had used narcotic drugs other than marijuana for a year or more. Of the white group, 1.7 per cent had used drugs, .5 per cent seriously.

The question arose about some special treatment program for the drug users. The psychiatrists undertook a more detailed study to individually evaluate each drug user. Some of the questions we attempted to find answers to were: Is there a difference between the drug user and non-drug user in regard to sociological background and psychological make-up among the inmates at this reformatory? What percentage could benefit from some type of group psychotherapy or individual psychotherapy? Is there some type of specialized milieu or educational program that should be set up exclusively for the drug user?

II. DESCRIPTION OF DATA COLLECTED

We studied 50 drug users and 50 non-drug users in the reformatory. The following general data were collected: name, number, age, race, religion, offense, sentence and conditional release date, number of previous offenses.

The Authors

● Dr. Todd, Columbus, is senior attending, psychiatry and neurology, White Cross Hospital; attending staff, University Hospital; co-director, Mental Hygiene Clinic, Ohio State University; assistant professor of psychiatry, Ohio State University College of Medicine.

● Dr. Bleak, Columbus, attending in psychiatry and neurology at Grant and Children's Hospitals.

SOCIOLOGICAL DATA

The sociological data collected on each subject were as follows:

1. What was the social-economic status of the family (upper, middle, lower)?
2. Had he spent most of his life in a rural or urban community?
3. How far did he go in school?
4. What was the family structure?
 - a. Did he come from a "broken" home? (The criteria we used was absence of a parent before the age of 16 through death, prolonged illness, or separation, etc.)
 - b. What was nature of father's contribution (economic, emotional) to the family?
 - c. What was the nature of the mother's contribution to the family?
 - d. How many siblings were there?

Submitted March 23, 1956.

- e. Was he married, have children and how did he function as a father?
- 5. What were his ethnic origins?
 - a. Were his parents immigrants, or first or second generation Americans, etc.?
- 6. At what age did his delinquency begin? (Here we did not consider just police record alone, but truancy, overt antisocial behavior.)

PSYCHOLOGICAL DATA

The psychological data collected were:

- 1. What was the nature and quality of the interpersonal relations in his family and with others now?
- 2. What is his concept of self?
- 3. What psychological symptoms does he now exhibit or report?
- 4. Is there history of previous mental illness?
- 5. What were the results of the Minnesota Multiphasio Personality Inventory?
- 6. What was the subject's future plans?

CLASSIFICATION BY CATEGORY

Psychiatrically we classified the drug user into six main categories:

- 1. Neurotic.
- 2. Character disorder.
- 3. Sociological character disorder.
- 4. Psychotic and borderline psychotic.
- 5. Mentally defective.
- 6. No apparent personality disturbance.

Except for the term sociological character disorder, we used criteria of the APA Classification of Mental Disorders. Out of this study we developed the concept of sociological character disorder.

The traditional character disorder has as its main causative factors those primarily intra-familial, such as failure of normal introjection or identification with parents, failure to incorporate their ideals, sociably acceptable attitudes and expressing needs by "acting out."

In contrast in the sociological character disorder the main factors were primarily sociological such as growing up in high delinquency areas, where the mores of that area and group allowed activities which were regarded as anti-social in other groups, i. e. son identifying parental attitude that "If you don't get caught it's all right"; or absence of any real family structure, an individual making identification with the street gang. In other words, the community in these areas tended to support actions which were "wrong" according to law and these mores were related to complex sociological factors including deprivation of basic needs of food, shelter and clothing e. g. Negro, Puerto-Rican groups in slum areas. From this study sociological

character disorder appears to develop because the attitudes toward the minority group by the majority "in-group" prevent any positive identification with the laws and mores of the majority group.

Superficially there may be many similarities between the foregoing disorders, but dynamically they are quite different.

CLASSIFICATION DEFINED

From the data collected there appeared the following classification of drug users:

- 1. **Symptomatic:** Drug usage was primarily a symptom of a psychological disturbance. Drugs alleviated subjective discomfort.
- 2. **Associated Factor:** Drug usage was only one manifestation of a long succession of anti-social behavior of a sociological or character disorder basis.
- 3. **Accidental:** Drug user showed no evidence of a psychological disturbance, or history of anti-social behavior prior to drug addiction.

TABLE 1.—CLASSIFICATION BY CATEGORY

Categories	Drug Users	Controls
a. Neurotic	Negro 10% White 8% Total 18%	10%
b. Character disorder	Negro 18% White 10% Total 28%	5%
c. Sociological character disorder	Negro 36% White 2% Total 38%	40%
Total of b and c	66%	45%
d. Pre-psychotic	Negro 0% White 4% Total 4%	0%
e. Mental defective	Negro 6% White 0% Total 6%	5%
f. No apparent personality disturbance	Negro 32% White 0% Total 32%	45%
Total apparent personality disturbance	68%	55%

Note—Total greater than 100% because some cases fit in more than one category.

TABLE 2.—CLASSIFICATION OF DRUG ADDICTION (see definition)

Symptomatic	Negro 12% White 6% Total 18%
Associated Factor	Negro 54% White 8% Total 62%
Accidental	Negro 20% White 0% Total 20%

TABLE 3.—COMPARISON OF DRUG USERS
AND CONTROLS

	Drug Users	Controls
Broken Home	72%	75%
Nature of Offense		
1. Mail Theft and/or Forgery	54%	25%
2. Narcotic Law	14%	0%
3. Car Theft	14%	25%
4. Robbery, Burglary	20%	25%
5. Other	4%	25%
Concept of Self		
Dissatisfied	32%	30%
Equivocal, Guarded	4%	10%
Satisfied	52%	60%
Unrealistic	10%	0%
Total Not Satisfied	42%	30%
Future Plans		
Hopeless	18%	15%
Indefinite	26%	15%
Definite	28%	60%
Unrealistic	28%	10%
Total Not Definite	72%	40%
Relationship with Others		
Stable	32%	70%
Egocentric	24%	10%
Isolated	8%	10%
Equivocal	16%	0%
Poor	28%	5%
Total Not Stable	60%	25%
From Large Cities		
Over 500,000	90%	70%
Small Cities, (rural)	10%	30%
Intelligence Quotient	98	97.2
Economic Status		
Low	80%	80%
Middle	20%	20%
High	0%	0%

III. RELATION TO OTHER STUDIES

Studies in the past of drug addiction have tended to explain its etiology either on a psychological basis (need arising out of the person's own personality disturbance), sociological (due to various community situations and pressures) or on a more holistic basis, a combination of these two factors.

It is quite natural that psychiatrists have depended on a psychological explanation, as they tend to see this mass phenomenon from that point of view. Reichard tends to limit etiologic considerations of drug addiction to the psychological make-up of the person who is exposed to narcotic drugs. He speaks of three factors as determining whether or not a person will become an addict. These factors are (1) degree of subjective discomfort, (2) ability to endure discomfort, and (3) strength, character and orientation of internal controls. Vogel tends to recognize other factors than psychological disturbance as being etiologic. He points out that a large percentage of the adolescent drug users have no well defined psychological disturbance, but take drugs because of the desire to conform to the "gang."

Pescor in his studies tends to relate the use of drugs to the tendency of youth to seek adventure, excitement, new thrills, and escape from an uninteresting reality. Kolb classified them etiologically into two classes, "pure dissipators" and those medically addicted. Under "pure dissipators" he broke this group into the various psychiatric entities.

Our study tends to confirm the value of a

more holistic approach with an evaluation of psychological and sociological factors and their interrelatedness in such a mass phenomenon. More about this appears in our conclusions.

In comparing this study with others it must be kept in mind that this is a particular group which is characterized by being juvenile—(ages 16 to 24)—federal law violators; but nevertheless some general kinds of comparison can be made with other statistical surveys of this problem.

Age: In 1938 the average age of addicts at the USPHS Hospital, Lexington, Kentucky, was 27.5 years. The average age of our group was 20.0. Vogel indicates that the average age of their addicts is decreasing at the USPHS Hospital mentioned above with the influx of juvenile addicts.

Opiate drug users: In the past 15 years there has been a shift from using predominantly morphine to using, in our group, almost entirely heroin. This of course could be determined by many factors, the most important being availability.

Anti-social Record: Pescor makes note that the anti-social record of his addicts was second only in prominence to their addiction. Of his group 71 per cent were prisoners. In our group about 30 per cent of these men probably would not be in a penal institution were it not for their drug addiction which was a main contributing factor in breaking the law. These men are made up largely of the groups where their drug addiction was either symptomatic of a psychological disturbance or they were accidentally addicted (see definitions).

About 70 per cent of our group had a prior delinquency record and it was felt their addiction was not etiologic in their offenses.

Race: In Pescor's study the ratio of white to Negro was 10 to 1 whereas in our study the ratio was 1 to 9. We feel that this difference is related to sociological factors which will be discussed later in this paper.

Rural vs. Urban: Ninety per cent of our group came from cities over 500,000 population whereas earlier studies indicated that this was not so predominate 15 years ago.

Alcoholism: Alcoholism has been reported as preceding addiction in one-third of cases in one study. However, among our group this played little or no role.

Psychiatric diagnosis: Our breakdown into various nosological entities and diagnoses was quite comparable to Pescor's study, with two important differences: Our feeling that sociological forces played a large role in many of our cases, diagnosed as sociological character disorder, and the relatively large number, 32 per cent, with no apparent personality disturbance.

Miscellaneous: Some factors were essentially

the same as previous studies regardless of age. These are educational attainment, religious training, occupation, marginal economic status, and no particular incidence of physical disease.

IV. THEORETICAL CONSIDERATIONS

1. **Pre-Conceived Ideas.** Prior to making this study the authors from their experiences in clinic and private practice as well as from the literature had a number of preconceived expectations. One of them was a feeling that we might find our drug user group to be a distinctive personality type when compared with the total institution population. As indicated in the review of the literature some of the most recent popular concepts have been of an "addictive personality," that of a passive dependent individual seeking an escape from the more pressing problems of reality and resulting anxiety.

We can see from our statistics immediately that in only 18 per cent of our cases was the drug addiction predominantly symptomatic of psychological need. In the other 82 per cent it was (1) an associative factor of other delinquent behavior (62 per cent); or (2) accidental, due to easy access and desire to go along with the group (20 per cent).

2. **Sociological factors.** As we reviewed our data the importance of several sociological factors appeared in the greatest majority to be more important than any specific psychological difficulty. First was the importance of the availability of the drug. Ninety per cent of drug users came from large cities of over 500,000 where illicit drug traffic is a profitable business. A second important factor was the use or acceptance of drug usage by the group with which subject associated. Of our group over 80 per cent (accidental and associated factor group) used drugs because of some need to do what the others with whom they associated did. A third important factor was the predominance of drug users from minority groups in our culture. At least 90 per cent were from Negro and Puerto Rican (86 per cent Negro—4 per cent Puerto Rican) groups.

Associated with these three distinctive sociological factors were the following: (1) Broken homes 72 per cent (absence of one or both parents in the home before the age of 16, due to death, divorce, separation, desertion, or chronic hospitalization); (2) low economic standards (80 per cent); (3) by far the majority used marijuana first as a precursor to using heroin.

3. **Comparison of Drug Users and Controls.** As to degree of psychiatric disturbance, we found that many of our Negro controls (actually 35 per cent but we suspect more) experimented with marijuana or heroin once or sporadically without becoming addicted. It is felt probably some of these could have become drug addicts had they not been picked up and confined for their present

offense. Many of the controls (70 per cent) came from cities over 500,000 but the immediate group they went around with day by day did not use drugs habitually.

a. **Diagnostic Categories.** In general the drug users had more personality disturbances (65 per cent) compared with controls (55 per cent). We felt this was not a marked difference.

b. **Concept of Self.** In general drug users had more disturbance in this area (42 per cent) as compared to (30 per cent of) the controls. We did not feel this to be markedly significant.

c. **Future Plans.** In the drug user group 72 per cent did not have realistic well motivated plans for the future as compared to 40 per cent of controls. From the data we collected this seemed to be a significant difference between the drug user group and the controls. This might indicate that the degree of importance of immediate pleasure and gratification as compared to long-termed goals is highly significant in drug users as compared to our controls; or, an alternative hypothesis is that the experience of being addicted to drugs favors ego-regression.

d. **Relation with Others.** Drug user group had a total of 60 per cent unstable interpersonal relations as compared to 25 per cent of controls. From this data we felt there was a significant difference between the drug user in his relations to other people as compared to controls.

4. **Type of Offenses.** From our data the most significant difference was predominance of Mail Theft and Forgery of Government checks. There were 54 per cent of drug users convicted of this offense as compared to 25 per cent of controls. In general the drug user's offense was more likely to be goal-directed toward obtaining money to support the drug habit with a preference for non-violent means of obtaining it, e. g. preference of lifting government checks from a mail box rather than burglary or armed robbery. Very few drug users would impulsively take a car for a joy ride or travel as compared to general population.

5. **Comparison of White and Negro Group of Drug Users.** Because of small number of white drug users no special detailed statistics were tabulated, and we felt the number was too small to draw any valid conclusions. In general, however, white drug users as a group appeared much more severely psychologically disturbed, i. e. pre-psychotic personality structure, etc. It might be said that personality disturbance was more important than sociological factors in the white group, whereas the reverse was true in the Negro group.

V. TREATMENT

1. **Neurotic and Pre-Psychotic Groups** (22 per cent of drug users). Drug usage mainly symptomatic, because of prevalence of anxiety and subjective suffering, this group would be moti-

vated to seek help. It has been our experience that most of this group seek help and 60 per cent of this group have been or are receiving individual or group psychotherapy.

2. No Apparent Personality Disturbance (32 per cent), Drug Usage Mainly Accidental. With this group no special psychiatric treatment is indicated. This group should be most amenable to educational measures. Straightforward directed group discussions, showing of films of unpleasant consequences by non-psychiatric personnel probably would be helpful. Sociological factors play a decisive rule in a prognosis, e.g. whether or not upon release they associated with drug users. With individuals in this group acquiring some skills or being trained for some satisfactory job would be thought to be of definitive value in future adjustment.

3. Character Disorders (28 per cent) Sociological Character Disorder (38 per cent) (total 66 per cent), Drug Usage Mainly Associated Factor in This Group. This group is made up of the drug users where antisocial or delinquent pattern was evident prior to drug usage. With the character disorder group, psychotherapy, educational program or advice (in general verbal means *per se*) will have little influence on this group. Day to day therapeutic living experiences (milieu treatment) may be of some assistance to this group. One suggestion to be further explored is formation of an addicts anonymous group along the same lines as those of Alcoholics Anonymous.

VI. CONCLUSIONS

From this select group of adolescent drug users our conclusions are as follows:

1. Adolescent drug usage is by far more prevalent among the Negro urban lower economic class in large cities over 500,000.

2. Sociological factors are more important in adolescent drug usage than individual psychological factors. These factors are:

- a. Availability of drug.
- b. Association with group who used drugs.
- c. Being in a minority group.

3. The significant psychological differences are as follows:

a. Drug users were more concerned with immediate pleasures than long-term goals, than controls.

b. Drug users as a group have less stable interpersonal relationships than the controls.

4. As a group the white adolescent drug user showed more psychological disturbance and sociological factors played a less dominant role in comparison to the Negro user.

5. Drug usage is not just an attempt to gain relief or escape from disturbing psychological symptoms, but a resultant of complex interacting social and cultural forces.

VII. SUMMARY

Adolescent drug usage is by far more prevalent among the Negro urban lower economic class. A majority have been behavior problems in school, participating in street gang activities. A large proportion come from broken homes. Their personality structure is such that they tend to "act out" psychological tension against a hostile environment rather than evidencing "intrapyschic" conflict.

With poorer family background from the start, less education and opportunity for training, their opportunities for social prestige and economic security in socially acceptable ways are limited. Because they are a minority or an "out-group," they have to advance against increased cultural barriers. Within this setting they may seek to escape or to compensate for their unpleasant reality situation. One escape is drug usage. Because the majority of this group experience conflict with the environment rather than intrapsychic, they feel little or no need for psychotherapy. Indeed drug addiction is not just a psychological problem, but also a reflection of social and cultural problems of our present American civilization.

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The Factor Responsible For the L. E. Cell

In 1948, Hargraves, Richmond and Morton reported that they had frequently observed segmented neutrophils containing homogeneous cytoplasmic inclusions of nuclear origin in heparinized bone marrow preparations from patients with systemic lupus erythematosus (hereafter designated as S.L.E.). They introduced the term "L.E." cell. This discovery afforded for the first time, since the original description of the disease by Kaposi, in 1872, a laboratory test with some degree of reliability for the disease S.L.E.

The factor responsible for the L.E. cell has been shown to be an antigenically specific gamma globulin present in the plasma of the patients with S.L.E. The etiology of this abnormal gamma globulin and the mechanism through which it acts on the nuclei of cells are as yet unknown.

The cytoplasmic inclusion of the L.E. cell has been shown to contain desoxyribose nucleic acid in a depolymerized state.—E. N. Gouldin, M.D., and L. W. Diggs, M.D., *Memphis: Southern M.J.*, 49:560, June 1956.

Accidental Severe Overdose of Paraldehyde With Recovery: Case Report

ALBERT J. GILBERT, M. D.

CASE REPORT

MISS _____, age 63, weight 124 pounds, was admitted to Aultman Hospital, Canton, Ohio, on March 16, 1955, for extraction of a senile nuclear cataract of the left eye.

Physical examination showed a well developed, well nourished, white female, not acutely or chronically ill. Temperature, 99.2°. Pulse, 64. Blood pressure, 164/82. Opacity present in lens of left eye. Heart and lungs normal.

Past history revealed blurring of vision for six months, and pneumonia one year ago. Otherwise noncontributory.

Routine preoperative orders of the attending surgeon were copied by the nurse from a type-written card. Drugs ordered were: 10 per cent neo-synephrine® eye drops; seconal®, grains 1½ at bedtime and repeated 1 hour preoperatively; demerol® 50 mg., ½ hour preoperatively. Shortly after midnight on the night of admission, the surgeon telephoned an additional order for paraldehyde, 6 drams rectally, 1 hour preoperatively. The nurse wrote the order as 6 ounces, read the order back twice, and somehow through a misunderstanding the order was confirmed.

At 6:30 a.m. on March 17, the patient was given 1½ grains of seconal® orally, and 6 ounces of paraldehyde rectally. At 7:00 a.m. she was given 50 mg. of demerol® intramuscularly. She was taken to the operating room at 7:30 a.m. Under local anesthesia, a cataract was extracted from the left eye. At the conclusion of the operation, at 8:30 a.m., it was noted that the patient was cyanotic. Respiration was very shallow. Blood pressure and pulse were not obtainable.

An anesthesiologist was called from a nearby room. Artificial respiration with oxygen was given, using an anesthetic machine. 0.2 cc. of epinephrine 1:1000 was given intravenously, with restoration of systolic pressure to 140.

At 8:55 a.m. the patient was transferred to the recovery room. She was in deep coma. Blood pressure was 110/60. Pulse was 78. Respiration was slow and irregular. Color was fair. Oxygen was started per mask, and later was changed to nasal catheter. 1,000 cc. of 5 per cent dextrose was started intravenously. An indwelling catheter was placed in the bladder.

At 9:30 a.m., blood pressure fell to 90/50. Respiration was irregular and shallow. 0.5 Gm. caffeine and sodium benzoate was given intravenously, with no improvement of blood pressure or respiration. At 10:05 a.m., 20 mg. of amphetamine sulfate was given intravenously. Blood pressure quickly rose to 146/80, and respiration improved.

Insertion of a rectal tube, with suction and irrigation, was not performed until 11:00 a.m., at which time about 10 cc. of fluid with a strong paraldehyde odor was removed.

The patient remained asleep for 80 hours, and was in a state of coma for 72 hours of that time. During this period she received three doses of amphetamine sulfate, 20 mg.; nine doses of picrotoxin, 6 mg.; and two doses of caffeine and sodium

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benzoate, 0.5 Gm.; all intravenously. None of these drugs produced any temporary waking effect, as is usually seen when they are used in barbiturate poisoning.

To prevent pneumonia, the patient was given fortified duracillin®, 1 cc. intramuscularly, twice daily for two days; then tetracycline, 100 mg. intramuscularly every four hours for two days.

Intravenous fluids consisted of 1,000 cc. of 5 per cent dextrose, plus 2,000 cc. of 10 per cent travert® No. 1 (a mixture of invert sugar, sodium lactate, sodium chloride, potassium chloride, calcium chloride, and magnesium chloride), daily.

On the second postoperative day, the patient's temperature rose to 101.2°. This gradually returned to normal by the fourth postoperative day. An allergic-type rash appeared over the back on the fourth postoperative day. This was treated by chlor-trimeton®, 4 mg., three times daily, and disappeared in about three days.

Although the patient was turned frequently, she developed a large blister over the right heel, and a decubitus ulcer at the back of the head. The lesion on the heel healed quickly after the blister was opened. The ulcer at the back of the head healed by granulation in three months.

COMMENT

A 63-year-old woman survived an extreme overdose of 180 cc. of paraldehyde by rectum. The essential parts of the treatment which proved successful in this patient were:

1. Epinephrine intravenously against acute circulatory collapse.
2. Oxygen inhalation.
3. Fluid administration intravenously during the period of coma. This consisted of 1,000 cc. of 5 per cent dextrose, and 2,000 cc. of travert® No. 1, daily.
4. Amphetamine in doses of 20 mg. intravenously to support blood pressure and possibly stimulate respiration.
5. Antibiotics to prevent pneumonia.

Caffeine and picrotoxin, in the doses used, appeared to have little effect on the course of the coma.

In retrospect, it is likely that at least one beneficial procedure was omitted. A significant amount of paraldehyde might have been removed by rectal irrigation within an hour or two after administration of the drug. Only a very small amount was obtained five hours after administration.

Submitted November 21, 1955.

Some Reflections on Group Psychotherapy, A Growing Force in Psychiatry*

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THE group method of dealing with medical and emotional disorders has a relatively long history, but it is only within recent years that group therapy has become more psychodynamically oriented and applied to the fuller understanding and treatment of personality disorders.

The group method is distinctly an American contribution, and as Slavson⁸ has indicated may be reflective of our American culture. This is essentially a free group culture in which have evolved our present-day labor unions, social group work and recreation groups.

HISTORICAL SURVEY

Pratt⁶ in 1905 first utilized the "class method" with a group of tuberculous patients for the purpose of stimulating recovery from a physical illness. These groups were large, consisting of as many as 100 or more patients. The procedure consisted of explanations as to the nature of the disease and the meaning and intent of the various therapeutic measures. By such intellectual understanding, the patients were enabled to cooperate more fully in their treatment than if they had been obliged to follow blindly a routine without appreciation of its meaning. Pratt's method was largely inspirational as he attempted to correct attitudes that would interfere with the recovery from physical illness.

Subsequently, others such as Buck,² Hadden³ used the "class method" with patients suffering from hypertension, diabetes, peptic ulcer and obesity. These groups were essentially inspirational, authoritative procedures in which patients would discuss themselves much in the nature of a revivalist meeting or as in Alcoholics Anonymous. The group instruction was used primarily as adjunctive to medical treatment and thus the aims and methods were not entirely identical with psychotherapy.

Deviation from the group method of instruction gained its inception in 1936 when Schilder⁷ and Wender¹⁰ published their accounts of focusing treatment upon the intrapsychic structure of the patient which was more suited to the therapeutic needs of the neurotic. Here the group was used specifically as a therapeutic aim and not ancillary to medical treatment. The orientation was basically psychotherapeutic and drew largely from psychoanalytic concepts.

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Since then a large body of literature has grown in excess of 1,000 publications in which interest has been centered on the psychological process and techniques of applying such knowledge to the psychotherapy of patients in groups. The various aspects of group therapy have included activity and play therapies with children and adolescents, didactic groups and the analytic group therapies.

Considerable impetus towards group orientation was stimulated by World War II with the pressure of having to deal with great numbers of patients with acute and temporary disturbances. These could be helped to overcome acute reactions to fear and stress through group support and ventilation of their emotional distress. This is, however, not pertinent to deep personality change as is being attempted with present-day group therapy.

In recent years through the organization of the American Group Psychotherapy Association and the American Society of Group Psychotherapy and Psychodrama, there has grown an ever increasing interest and striving towards a psychotherapy which aims to effect within varying degrees changes within the personality structure. The extension now of group principles to areas outside of strictly therapy groups to the areas of industrial relations and education is an interesting and stimulating venture.

Slavson,⁹ Moreno,⁵ Wolf,¹¹ Loeser,⁴ among others, have published reports both in theory and technique of group psychotherapy in its various aspects from the strictly activity and play groups, to the discussion, analytical and psychodramatic expressive groups.

PRESENT STUDY

This report is a review of reflections in the use of analytical group psychotherapy during the past several years at Mt. Sinai Hospital Psychiatric Clinic and in private practice. Interest in group psychotherapy was suggested in great measure because of the possibility of dealing with a large case load which was far in excess

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Submitted November 19, 1955.

of available psychiatric time, and to learn more regarding this relatively new approach to psychotherapy.

Five groups have been observed during this interval, one of which was in the author's private practice. The first two groups, composed of five chronic alcoholic men and of seven women, respectively, met quickly with failure—such that little conclusion could be drawn from the observations in therapy with these groups. The inexperience of the psychiatrist, plus the inherent difficulties in the selection of the patients, perhaps were factors to be considered in the failure. The third group was composed of 10 women, and a current fourth group composed of three men and four women. The group in the psychiatrist's private practice was also a heterogeneous group of seven individuals. The composition of the groups have varied from time to time because of those who drop out of therapy and, also, by the introduction of new members to the group.

SELECTION

In the selection of the third group at the Psychiatric Clinic all of the women patients were drawn from cases where individual therapy had been tried, but which for various reasons was unsuccessful. These, then were placed in a group to see what results could be obtained with such a program. Similarly, in the present group all have had some individual therapy with other psychiatrists prior to coming to the group. Two patients in the current group have returned from periods of absences from the prior group for further therapy. By and large, patients have been introduced to groups who had experienced unsuccessful therapy individually either with the group therapist or with other psychiatrists over a period of time. This, it was felt, posed a real challenge in that it would perhaps highlight any values that would specifically accrue from the group situation *per se*.

In the selection of the groups, consideration was given toward achieving some degree of uniformity as to age, intelligence and cultural level. Overtly psychotic individuals, overt homosexuals, the asocial or the psychopathic character disturbances were excluded. Thus, the groups were limited to primarily neurotic or character disorders, but with the admission of a few borderline psychotic patients who still maintained a good contact with reality.

Thought was given to characteristic modes of personality reaction in order to obtain a composite group composed of many variables. Thus, the aim was to select individuals who would tend to supplement as well as to complement each other in their interpersonal reactions. It seems that in the composition of the group, individuals should be chosen to form a heterogeneous group which would lend itself to the stimulation of interpersonal reactions, and thus reveal underlying personality trends. Otherwise, a group heteroge-

neous as to personality structure would tend to reinforce each other's defenses.

METHOD OF APPROACH

All of the groups met once weekly for 1½ hour sessions. All of the meetings were recorded either by means of a tape recorder or through the use of an observer who was either the clinical psychologist or the psychiatric social worker. The women's group, the first successful group, met for a total of 86 sessions. There was considerable flexibility during the course of treatment regarding the use of individual sessions. The patients were apprised of the availability of individual interviews if needed from time to time. Several of these patients actually were carried with combined individual and group sessions, half of them dividing their time individually and with the group, while the remainder saw the therapist only occasionally, for a limited period of time.

In the current group, which is the mixed group, time for individual therapy was held to a minimum and limited only to periods when there was an immediate problem which for various reasons had failed to be worked through in the group sessions. Members were told that individual sessions were available to them but only after all attempts at group participation were attempted.

INTRODUCTION OF PATIENTS TO THERAPY

The group program is of an analytically oriented type of therapy in contrast to an activity, discussion, or an authoritative inspirational type of approach. At the initial session all the patients were informed as to the approach to therapy, namely that they were there to learn about their problems, to receive help from the psychiatrist as well as from the other patients in the group. They were acquainted with the fact that the group, as structured, was different from a social group in that they would discuss matters both personal and intimate, and that they would examine closely their interpersonal reactions.

Patients were encouraged to freely express feelings and thoughts and it was hoped that this would thus minimize the pressures of censorship. It was explained that from time to time they would perhaps emotionally react to each other and to the psychiatrist, and it was necessary and important to examine the basis for their interpersonal reactions and feelings. The goal as described was to promote *mutual* endeavor towards the resolution of their problems.

Since the therapist was aware of the possibility of social contacts outside of the group, the group was informed of the fact that this might occur, but it would be to their advantage to report such happenings back to the group for further contributions towards insight into their own problems. In the heterosexual group, particularly, socialization was perhaps fraught with more

psychological danger and the group was apprised of this in an attempt to preclude any heterosexual acting out which would be a loss to the therapeutic process.

The therapist was described as being one who helps contribute from his fund of knowledge in order to help explain some of their reactions to each other, as well as to be a *sounding board* for many of their own emotional reactions.

Patients were also encouraged to bring dream material which could be presented to the group and utilized not only to help the individual who brought the dream, but as a means of stimulating associations of other group members and utilizing this for deeper understanding of their own problems.

PROCESS OF THERAPY

In all of the groups observed there was an initial period during which the group was learning about each other and about their problems. As one can expect this initial warm-up period lasted from 10 to 20 sessions. This was the period when the social barriers were quite prominent and, as was anticipated, it was with some difficulty that patients could allow themselves to freely express their own problems. There were many attempts to place the therapist in the teacher-parent role, and to place the major burden of responsibility for therapy upon him.

The therapist, in contrast to individual therapy, is confronted not only with observations of individual reactions but with the multiple complexities inherent in the inter-reactions of many individuals. This serves, also, to provide the therapist with a multidimensional view of the patient which is not possible in individual therapy. Usually, one can expect certain individuals within the group to attempt to monopolize by lengthy discourses of their own histories or by presenting an immediate reality problem. Such usually can be informative for the group, but frequently are to be considered as resistances and need to be dealt with by both the group and the group therapist. This was especially apparent during the initial period of therapy and the psychiatrist needed to stimulate group participation by remarks about what he tentatively might see within a particular situation, or by calling attention to the various inter-personal reactions toward each other.

Through observations of the way the therapist approaches the problem the various members of the group soon become in a measure therapists in their own right; that is, they begin soon to take over the major responsibility of examining their inter-personal reactions and exploring the basis of their feelings toward each other and about oneself.

SOCIALIZATION

As the group progresses there begins to develop a certain cohesiveness and sense of belonging.

During this period socialization usually begins, occurring frequently after the group session. Members have gone to a local coffee shop to carry on the meeting where it left off, and have from time to time met with each other in their homes, or in other meeting places during the absence of the therapist. This, as could be anticipated, was frequently used as a resistance and there was considerable difficulty encountered here. However, it is the author's belief that socialization cannot be prevented and, therefore, it should be used as far as possible as part of the total program.

Frequently when such information was returned to the group, many of the transference reactions not only toward the therapist but towards each other were highlighted. For example, in the women's group there was a period of time when little was being accomplished in the group sessions when suddenly it was brought to light that seemingly much more was discussed afterwards in the coffee shop when one of the group members was not present. This particular member had aroused considerable resentment in the group because of her habitual tardiness and tendency to monopolize the attention of the group. By exploring their hostile feelings toward her, the resistance was subsequently resolved.

PSYCHOLOGICAL FACTORS SPECIFIC TO THE GROUP SETTING

There appears to be certain psychological features in the group setting which distinguishes itself from individual therapy, and which can be particularly useful in dealing with certain types of patients. Three areas in which this would seem to be particularly applicable are: (1) the effect upon fears of isolation and of uniqueness; (2) modification of the intensity of the transference; and (3) opportunities for practical application and testing of reality.

(1) ISOLATION

A characteristic feature of the group is that the very structure of the situation provides less pressure for individual participation. The demands upon the patient are somewhat less than is true in individual therapy, and patients can readily remain uncommunicative or withdraw whenever they deem necessary. The presence of other individuals who are able to lend support enables the very fearful patient and those who are very resistive subsequently to remain in therapy. The very nature of the group thus minimizes the fear of uniqueness that is so constant among patients in therapy. The fear of being different and isolated thus is minimized in the group where patients gain assurance through identification with others who have similar or related difficulties.

FOR EXAMPLE, one patient in her middle thirties came to therapy asking specifically to become a member of a group. She had been in individual therapy intermittently over a period of eight

years for a recurrent phobic state which thus far had been unresolved. It was after joining the group that she was able to reveal that the basis for her resistance to individual therapy was related to an exhibitionistic need that she could not reveal in the presence of her therapist. Also, she had maintained a strong prudish defense which she could relinquish only by means of the support of other group members.

Interestingly, this patient had quit her prior therapists each time when the subject of her sexual impulses were to be revealed. After she had learned from other members of the group regarding their sexual conflicts, she was then able to discuss her problems with them with subsequent amelioration of her phobia. Seemingly, the factors involved in her use of the group were in the satisfaction of certain exhibitionistic needs to display herself, as well as being able to discard her prudishness which she could do in the group medium with lessened fear of censorship.

(2) TRANSFERENCE MODIFICATION

A feature of the group is the opportunity for the regulation of the intensity of transference involvement. The term *transference* is employed to designate the similarities in the feelings and attitudes a patient has towards the therapist and the significant figures in his life. The patient, so to speak, transfers his feelings from parent to doctor accepting the latter in *loco parentis* and reacting to him with associated feelings.

Ordinarily such feelings towards one's parents or other significant individuals are repressed and censored if they involve attitudes that are felt to be unacceptable by the individual. Thus they cannot be revealed consciously without a special therapeutic setting. Dealing with such feelings is the pivot of psychoanalytical therapy. It is in such a setting that patients are enabled to move from themselves to an object relationship with the therapist as the transferred significant person or persons.

In groups the transference towards the therapist need not be as intense as may be so in individual therapy. The presence of other members with whom the therapist has to be shared and the inevitable reactions toward the other patients in the group will thus modify it. The possibility exists, also, that the transference reactions toward the therapist can be accentuated by virtue of the rivalry situations which may develop.

Here in the group, room exists for the individual to more or less regulate his emotional distance from others. Through the multiple opportunities available for emotional reaction with many patients, the emotional ties can be modified or lessened. This is particularly useful for patients within whom there is a fear of forming an intense transference to the psychiatrist. In the group medium, this can be mitigated by the

fact that there are more potential transference objects present to whom the patient can relate.

FOR EXAMPLE, a borderline psychotic patient was seen by the psychiatrist in therapy for approximately 1½ years. She was chronically depressed and a good part of the time uncommunicative. It was with considerable difficulty that she was able to relate at all to the psychiatrist and she formed a rather strong dependency transference upon him. It was quite apparent that a great deal of her difficulties was in her fears of becoming emotionally involved and thus the group was suggested for her.

In the group she began to make progress by maintaining her distance from the psychiatrist, but subsequently utilizing other group members to elicit her own transference reactions. Being highly intuitive, she was able to stimulate the reactions and interpretations of other group members, and soon became a useful and helpful member of the group. She eventually was able to quit therapy and continued to do quite well in her chosen field of work.

Subsequently this patient became pregnant and delivered a baby boy. Later when she again became pregnant she returned to the group. Seemingly, she used the group setting primarily for ego support during the time that she was pregnant. Her return to the group the second time was accompanied by a brief depressive episode which quickly lifted. She continued then to maintain a good contact with reality and was able to relate fairly well to other group members. She then terminated therapy approximately about the time for the delivery of her second boy.

She is now making a satisfactory adjustment without being in therapy. Borderline psychotic patients frequently are of value to the group as they often have an amazingly good intuitive grasp of other people's problems which can be quite useful for other members of the group.

(3) REALITY TESTING

Another valuable feature found in the group is the occasion for reality testing in an observable setting which is not always available during the course of individual therapy. Reality testing is an integral part of everyone's life. Individuals are constantly testing themselves in relation to everyday realities and learn more or less to make acceptable adaptations to the demands and limitations prescribed by the outer world over their inner drives. Many people fail to make such satisfying adjustments and take refuge in symptom formation or in other neurotic defensive attitudes.

In therapy as the patients' conflicts diminish, and with increasing awareness of the nature of their problems, there are attempts over and over to test their new found knowledge in relation to other people. Old established patterns of behavior and distorted attitudes based on childhood adjustments can be discarded when no longer useful and newer, more appropriate attitudes can be adopted.

Ordinarily in individual therapy patients do test themselves outside of the therapeutic hour but a good part of this may be acted out without integration into the total therapy. The therapeutic

tic group provides for a reality situation where patients are constantly confronted with reactions to the emotions of many individuals within the group. Here one can act out and react to others with all the varied emotions of anger, love, resentment, jealousy and dependence. These communications are thus examined and interpreted and elaborated by the therapist and group members.

The group thus exercises more of a pull toward reality orientation and in this respect the role of the group is primarily ego strengthening. The acting out of unconscious projections observed in relationship to the group provides thus the basis for an excellent re-educational experience. The fact that the group can be closer to most real life situations makes the acting out of unconscious fantasies much more apparent, and thus more amenable to interpretation and examination. This, of course, can be of great *practical* value especially when the patient is in combined individual and group therapy. Such practical experiences in the group make for considerable progress. In the group the patient is not only reacting to real people but as well to the special "unreal" figures of the therapist or other transference objects and thus making possible the correction of individual projections.

AN EXAMPLE of the foregoing was quite vividly illustrated by a former patient who came to the group because of problems of obesity and difficulties in relating to her children as well as to her husband. She was an only child whose father died when she was an infant. She had subsequently lived alone with her mother or with an uncle who had two daughters. Her feelings of inferiority were quite marked and she had a strong need to occupy the attention of the group. However, she developed considerable anxiety in reference to the group when she formed a rather intense positive transference to the therapist, and wished intensely to gain his full attention.

She began to compete with other members of the group for what was considered the favorite seat next to the psychiatrist. At one session she occupied this place. It was at this session that she was dressed in a rather simple printed dress which was called to the attention of the other members. She began to question each member of the group as to their reactions to what she was doing, fearing simultaneously their disapproval but needing to act out her wish to monopolize the psychiatrist.

Through the help of the group she was able to finally associate to the fact that the dress she had worn on this particular day was quite similar to one she used to delight in wearing in the presence of her uncle whom she would attempt to monopolize, and this was associated with her rivalry with her two cousins. It was through this acting out experience that she was able to resolve some of her intense needs to be the only child and again return to the idealized relationship with her father.

HETEROGENEOUS VS. HOMOGENOUS GROUPS

The analysis of acting out experiences and reality testing is seemingly facilitated to a greater degree in the heterogeneous groups than

in the homogeneous ones. The presence of both male and female more approximates social reality. The value of the mixed group is enhanced in that the presence of members of each sex facilitates many more significant reactions than may be observed in the homogeneous groups. The issues of masculinity and femininity are more readily elicited and available for study.

Another factor which seems to be advantageous in the mixed groups is the diminution of some of the emotional demands made upon the psychiatrist. The psychiatrist may be freed somewhat from problems of his own counter-reactivity by the presence in the group of individuals who unlike the therapist may provide gratification for the patient's neurotic needs. Heterosexual acting out may pose a problem and is currently a problem in one of the groups. Although it can be used as a resistance, it seems also to be of some therapeutic advantage as it may clarify underlying attitudes of the participants as well as stimulate the responses of other group members.

FAILURES

Failures that occurred during the course of therapy are of interest. Some of the patients who terminated therapy did so after the first few sessions and thus little is actually known regarding the dynamics for their withdrawal. The failures, however, that occurred after a period of time were somewhat better understood and will be briefly described here:

ONE OBVIOUS FAILURE was a woman who had been in therapy over a period of many years with another psychiatrist and had been placed in the group in an attempt to objectify her relationship with others as well as to facilitate separation from the rather intense dependency upon her psychiatrist. Her acceptance of the group was fleeting at best and she refused to separate herself from her dependency upon the psychiatrist. She was habitually tardy and made many attempts to destroy the group through her depreciation of the process as well as by her need to monopolize. Basically she was a highly paranoid individual with strong narcissistic needs, such that she was constantly thwarting and destroying many attempts at object relationships.

In some respects her need to thwart any progress in the group was related to her unconscious hostility against her psychiatrist toward whom she projected her resentment in terms of an expressed feeling that he was trying to get rid of her. When she was confronted with her need to make a decision regarding coming regularly and working through her problem in the group, and was faced with her underlying hostility toward the group, she decided to terminate her visits.

ANOTHER CASE was a woman with rather severe anxiety who had many phobias of impending death and heart disease. Characterologically she was quite rigid with many obsessive compulsive traits. She was very fearful of her unconscious hostility and of her sexual impulses, such that she constantly needed to defend herself against the group by either hostile denials of her feel-

ings or by defensive attacks upon other group members. Her rigidity was such that she could not accept any help offered by other group members and her level of anxiety was so great that she finally terminated her visits. However, she subsequently returned for individual therapy.

In individual therapy she still maintained this defensiveness but after a long period of time was able to discuss more freely some of her deeper feelings in relationship to her husband and mother. She had strong needs to dominate and control her husband who was a chronic alcoholic, and strivings to be superior to her mother with whom she was in competition. In the group it was quite apparent that she also attempted to direct and control the group according to her inner needs, and could not tolerate any breach into her defensive organization.

It is difficult to state whether such cases of intense narcissistic character resistances as described in the foregoing are in themselves contraindicated for group therapy. There are reports of patients with similar character structures who have been enabled to work through their personal difficulties somewhat better in groups. One would perhaps say that this is a matter for individual consideration rather than to make any large generalization regarding this as a contraindication for group therapy. Perhaps the best criterion for determining whether an individual will or will not work in a group is to make a therapeutic trial.

CONCLUSIONS

It is believed that group psychotherapy is a useful method which has its proper place in psychiatric therapy. It is particularly useful, it would seem, for patients who have strong character resistances and difficulties in recognizing their own emotional responses. The group can also be utilized to advantage in combination with individual therapy where resistance and transference difficulties can sometimes more readily be examined. It is also of value in cases where the intensity of the transference needs to be modified. Lastly, it would seem to be useful for preparing patients for later more intensive individual therapy.

As yet, no definite conclusions have been drawn from comparisons of those who are limited to group therapy and those who have combined individual and group therapy. Tentatively, it would seem that the combined efforts appear to facilitate more rapid progress and delineate somewhat more clearly the underlying issues.

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The Risk of Human Error In Cholecystectomy

How great is the risk of human error in cholecystectomy? Lahey is quoted as saying that he would rather see a surgeon of limited experience undertake a gastric resection than a cholecystectomy since he was somewhat less likely to get into serious trouble.

It is unfortunate that the term "simple cholecystectomy" has come into use. The truth is, that prior to operation and exposure, no surgeon can anticipate what will be found, what need be done, nor how difficult it will be to do it. There are few areas as subject to variations in anatomy, anomalies of the ducts and vessels and unexpected pathology. Even in the absence of unexpected difficulties, inadequate lighting, improper exposure, insufficient help or unsatisfactory anesthesia may put the best of surgeons at a great disadvantage and result in error.

Lack of familiarity on the part of the surgeon with anomalies in the region of the gallbladder is courting trouble. The cystic artery may arise from any of the nearby vessels. It commonly comes, of course, from the right hepatic artery which crosses behind the common duct. It may arise from the left hepatic artery, the common hepatic or the gastroduodenal. There may be one or more accessory cystic arteries of considerable size.

Perhaps the most dangerous anomaly is the right hepatic artery, which, arising from the superior mesenteric or else dipping down from its usual position, comes to lie very close to the cystic duct and gallbladder. In a series of autopsy examinations, the right hepatic was found within one centimeter of the cystic duct in 10 per cent of cases.

Despite the recent flurry of articles on hepatic artery ligation for portal hypertension and the ability of antibiotics to lessen the mortality rate of hepatic ischemia, ligation of any major part of the blood supply of the normal liver is still quite likely to result in a mortality.—Hart Hagan, M. D., and William Hagan, M. D., Louisville: *J. Kentucky State M. A.*, 54:505, June 1956.

Responses of Bacterial Infections of the Skin To Oxytetracycline-Hydrocortisone Ointment*

ASHTON L. WELSH, M.D., and MITCHELL EDE, M.D.

XYTETRACYCLINE hydrochloride (3 per cent) and hydrocortisone (1 per cent) in petrolatum, (terra-cortril® ointment) combines in a single dermatological preparation agents which have powerful antibacterial and anti-phlogistic action.

TOPICAL OXYTETRACYCLINE

Oxytetracycline has been used for several years in treating bacterial infections of the skin, and has proved to be effective against common skin pathogens when applied locally. Robinson,¹ in a recent study, has called attention to the successful use of oxytetracycline in treatment of impetigo, paronychia, otitis externa, folliculitis, and various infections secondary to other skin disorders; and other investigators have determined its usefulness in a wide range of skin infections. Tschan and Wright² have shown that topically applied oxytetracycline does not sensitize patients to subsequent systemic use of the drug.

TOPICAL GLUCOCORTICOIDS

Use of the glucocorticoids cortisone, hydrocortisone and fludrocortisone acetate (9- α -fluoro-hydrocortisone acetate) is being continually increased in the control of many inflammatory skin diseases. Hydrocortisone and fludrocortisone acetate are effective when applied topically.

In the last four years hydrocortisone products have had extensive topical use and to date no clinical evidence of systemic absorption, such as edema, weight gain et cetera, has been reported. No such reactions have been observed in the authors' series of 3,566 patients.

In the much shorter time that fludrocortisone acetate has been used topically, it has been observed to produce untoward clinical and laboratory evidence of systemic reactions from percutaneous absorption³.

It is the authors' opinion that incidence of absorption of sufficient degree to produce untoward systemic symptoms is relatively low. It has not occurred in our own series of 1,016 cases. It has been demonstrated that sufficient small amounts of hydrocortisone (1 to 3 per cent) are absorbed during topical use to produce depletion of sodium excretion in the urine³, and decrease in the melanocyte-stimulating hormones (MSH) in the urine⁴. Malkinson and Ferguson⁵ have also

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- Dr. Ede, Cincinnati, is instructor, department of dermatology, University of Cincinnati College of Medicine.

shown that small amounts of hydrocortisone-4-C¹⁴ were found in the urine after topical application of this radioactive tagged hydrocortisone. However, the amounts absorbed were insufficient to produce demonstrable depression of the eosinophil count; to increase urinary output of Compound F; to alter the 17-21-dihydroxy-20 ketosteroids in the urine; to raise the blood levels of sodium; or to produce weight gain³. It appears that the small amounts absorbed percutaneously are insignificant since the quantity is insufficient to produce untoward systemic effects.

It is still the opinion of the authors that instances of therapeutic effect on lesions distant from the site of application remain, at least in part, explained by the uncontrolled use of hydrocortisone on the part of patients since the small amounts absorbed would, in most instances, have been inadequate to produce the therapeutic effect observed on distant lesions. Hydrocortisone has been shown to be effective alone or with other therapy in the management of atopic dermatitis, dermatitis venenata, neurodermatitis, seborrheic dermatitis, stasis dermatitis and other primary dermatoses uncomplicated by infection⁶. We have previously reported its success when combined with other conventional agents in treating infectious eczematoid dermatitis⁶.

COMBINED TOPICAL OXYTETRACYCLINE AND HYDROCORTISONE

It is clearly advantageous to combine oxytetracycline and hydrocortisone therapy in the treatment of certain common skin disorders involving bacterial infection, since infectious elements may respond to oxytetracycline while hydrocortisone controls the underlying disorder through its anti-inflammatory action. Stritzler and Frank⁷ have reported that in secondarily infected dermatoses

*The oxytetracycline-hydrocortisone (terra-cortril®—trade name) topical ointment used in this study was kindly supplied by the Medical Department, Pfizer Laboratories, Brooklyn, New York.

Submitted March 17, 1956.

the combined topical therapy with oxytetracycline-hydrocortisone is more effective than with either ingredient alone.

The addition of the antibiotic to hydrocortisone for topical therapy is logical since hydrocortisone not only fails to afford bacteriostatic or bacteriocidal action but, in addition, impairs the activity of the injured cell so that it is unable to produce certain chemical factors involved in inflammatory reaction, particularly leukotaxine and the leukocytosis-promoting factor (LPF) both of which certainly aid in combating infection⁸.

Even in primary infections the combined therapy may be superior to oxytetracycline alone since hydrocortisone may relieve irritation and prevent aggravation of the lesion while the antibiotic combats the infecting organisms. Such action probably accounts for the fact that many patients while using the ointment containing both agents, experienced more subjective improvement than they did while using a similar ointment containing oxytetracycline (3 per cent) alone. Objectively it was noted than in post radiation lesions and lesions resulting from fulguration or cautery, particularly at mucocutaneous junctions such as the lips and perianal areas where dressings were impossible, response to oxytetracycline-hydrocortisone combined ointment was much more rapid and satisfactory than to either agent applied alone.

MATERIALS AND METHODS

Included in this study are the results of oxytetracycline-hydrocortisone ointment on 232 patients suffering from various skin disorders all of which involved a bacterial infection. In 170 cases the bacterial infection was secondary to other skin disorders, while in 62 cases it was primary.

This experimental group of patients included both children and adults seen in office practice, and excluded all patients who were not adequately followed, as well as all patients in whom bacterial infection was not demonstrable. Patients were instructed to apply oxytetracycline-hydrocortisone ointment to the affected areas three times a day, and were seen at approximately weekly intervals. While the test was proceeding, no other medication was used in any of the patients. Although in many cases it was necessary to continue therapy only a week, some cases required continuing therapy even after several months. The average duration of treatment for the infectious elements (both primary and secondary) was about one week, but use of the agent was frequently continued for two or three additional weeks, and in some cases months, to control eczematization or prevent recurrence of infection in denuded areas.

RESULTS

The success of oxytetracycline-hydrocortisone ointment therapy was evaluated in two ways: in

every case, the course of the bacterial infection was followed and was judged independently of any underlying dermatosis; in 128 cases infection was superimposed on a dermatitis susceptible to hydrocortisone therapy, and the influence of oxytetracycline-hydrocortisone ointment on the underlying primary dermatitis was judged separately. The result of therapy on bacterial infections is shown in table 1, where it is seen that

TABLE 1—EFFECT ON INFECTIONS

	Number of Cases	Therapeutic Response		
		Excellent	Fair	Poor
Primary Bacterial Infections				
Folliculitis	31	28	3	—
Paronychia	11	6	5	—
Perleche	11	2	8	1
Impetigo	6	6	—	—
External otitis	1	1	—	—
Pustular bacterid	1	1	—	—
Cheilitis	1	1	—	—
Total	62	45	16	1
Secondary Bacterial Infections				
	170	139	31	—
Total	232	184	47	1

quick eradication of the infection was brought about in 184 (79.3 per cent) of the 232 cases, slower improvement was obtained in 47 (20.25 per cent), and therapeutic failure resulted in only one case of the series (0.43 per cent). The one failure occurred in a woman with perleche who could not tolerate the oinment.

The evaluation of oxytetracycline-hydrocortisone ointment therapy in five types of primary dermatoses which occurred frequently in this series is shown in table 2. It is significant that

TABLE 2—EFFECT ON FIVE SELECTED PRIMARY DERMATOSES (NONBACTERIAL)

	Number of Cases	Therapeutic Response		
		Excellent	Fair	Poor
Atopic Dermatitis	41	39	2	—
Infectious eczematoid dermatitis	58	34	22	2
Seborrheic dermatitis	14	5	9	—
Dermatitis venenata	8	4	4	—
Neurodermatitis disseminata	7	5	2	2
Total	128	87	39	2

in only two cases of infectious eczematoid dermatitis was therapy without some effect in controlling this disorder, and that in over half the patients a complete clearing of the lesions was effected. The result was most gratifying in atopic dermatitis and in infectious eczematoid dermatitis. In each of these groups the large number of cases justifies the conclusion that oxytetracycline-hydrocortisone ointment therapy is an effective adjunct to treatment of these conditions.

Undesirable reactions to the ointment were noted in five cases, a total incidence of 2.15 per cent. In these patients use of the ointment was followed by an irritation of the lesions accompanied by a burning sensation in several instances. No systemic effects referable either to

hydrocortisone or to oxytetracycline were observed in any of the cases, even when the ointment was used over a period of several months.

SUMMARY

It is in skin disorders complicated by secondary bacterial infection that oxytetracycline-hydrocortisone ointment can be expected to evoke the most beneficial results. In the study reported here, all of 170 patients with dermatoses complicated by secondary bacterial infections of the skin were benefited. In 128 patients with selected dermatoses the ointment not only controlled infection that was present, but produced marked favorable response in the underlying disorder. In only five patients of a total of 232 studied were there observed any undesirable effects of the ointment; in these cases local irritation mitigated its therapeutic value. No systemic effects of either the antibiotic or the glucocorticoid component of the ointment were observed.

It is possible to conclude with justification that the concentrations of oxytetracycline and hydrocortisone employed here provide effective therapy in both bacterial infections and other inflammatory skin lesions, and yet cause minimal side effects.

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Timed Urine Specimens Favored For Pregnancy Testing

In all phases of pregnancy testing it is advantageous to have a 12 hour timed specimen rather than a random or first morning specimen. This is particularly true in the so-called "quantitative" tests where dilutions of a given sample are used, since the volume of urine excreted over a given period of time may vary 200 to 300 per cent.

There has been a recent trend towards the use of serum for pregnancy testing. With the more sensitive animals diluted serum gives accurate results but with frogs and toads a high percentage of false negative results will be obtained. Any patient who has a negative batrachian test with serum should have the test repeated with a concentrate of urine.—Edward H. Hon, M. D., New Haven: *Connecticut State M. J.*, 20:430, June 1956.

KEEPING UP WITH MEDICINE

• ONE OF THE reasons given for increase in cholesterol in the blood from eating lard and butter that is hydrogenated is the greater stability of the more saturated fatty acids and the inadequate amount of phospholipids which are probably necessary for the transportation of cholesterol.

* * *

• HYPOTENSION is not to be used as a diagnosis. Unquestionably there may be the rare person whose blood pressure is low enough to cause symptoms. Many of the psychoneuroses show a low blood pressure but it is the result, not the cause, of the condition. Most all uncomplicated allergic states are accompanied by hypotension but it does no good to treat it. It will improve as the allergy is controlled.

* * *

• VIRAL HEPATITIS is difficult to diagnose in its early stages and more particularly when there is no jaundice.

* * *

• SPECIFIC therapeutic agents are not available for treating viral hepatitis. Two general principles of management obtain: rest and restriction of activity, and adequate protein and calories.

* * *

• IN THE SKIN of those animals which depend upon antibodies for defense, the histamine in the skin may play a minor role. On the other hand in those animals which depend on phagocytosis for defense in their skin, histamine does play a role by producing a violent edema which dilutes and washes out the foreign material. One certain function of histaminase is to inactivate extrinsic histamine.

* * *

• THERE IS a tremendous increase in serum histaminase during a human pregnancy but not in other animals studied. This is produced in the placenta and in one day after the expulsion of the placenta there is no trace of the histaminase in the serum.

* * *

• IT SEEMS probable that histamine is formed within the cell and is largely stored or totally held within certain subcellular particles which are mitochondria-like in size.

* * *

• PATIENTS who are allergic to penicillin G may or may not be allergic to other preparations, such as penicillin O and penicillin V.

* * *

• CORTISONE has been shown to enhance infections caused by a number of bacteria, among which are streptococci, pneumococci, staphylococci, brucellae, typhoid bacilli, spirochetes, cornebacteriae, malaria parasites, trypanosomes, several varieties of fungi and the virus of poliomyelitis and influenza.—J. F.

Differential Diagnosis of the Red Eye

WILLIAM H. HAVENER, M. D.

REDNESS of the eye is a manifestation common to many disease processes. By far the most common cause is acute catarrhal conjunctivitis, a benign and self-limited superficial infection. The frequency with which conjunctivitis ("pink eye") is encountered may engender a feeling of security in dealing with red eyes. This sometimes leads to regrettable delay in accurate diagnosis and definitive therapy of the more severe eye diseases.

The following diagnostic features may be utilized in differentiating minor and major diseases causing a red eye:

(1) *Vision.* Definite reduction in acuity, whether checked with a Snellen chart or as reported by the patient, is a danger signal which the physician cannot disregard. Reduced acuity means that functional damage to the eye has already occurred.

(2) *Pain.* Very severe discomfort indicates serious or potentially serious involvement. Corneal epithelial abrasions, though they ordinarily heal without residual, are included as being potentially serious because of their vulnerability to infection. Absence of pain does *not* rule out major eye disease.

(3) *Opacities.* Debris within the eye (hypopyon, hyphema, fibrin,) and fresh infiltrations or ulcerations of the cornea are always manifestations of major eye disease. (Old corneal scars, lens opacities, etc., do not, of course, signify recent and active disease.)

(4) *Pupil.* Irregularities in size and shape of the pupil are produced by intraocular path-

The Author

● Dr. Havener, Columbus, is on the attending staff at University Hospital, and Acting Chairman, Department of Ophthalmology, The Ohio State University College of Medicine.

ology; never by insignificant superficial disease. (A noticeable degree of anisocoria occurs normally in 5 per cent of the population.)

(5) *Distribution of redness.* A limbal flush encircling the cornea indicates a seriously irritated eye. Quite sharply delimited sector involvement suggests an allergic rather than infectious etiology. Superficial vessels are redder, more tortuous, moveable by pressure through the lids, blanch with topical 1:1000 adrenalin,[®] and are solely involved in acute conjunctivitis. Deep vessels are less red, straighter, adherent to globe, do not blanch with adrenalin,[®] and indicate more extensive involvement than a simple conjunctivitis.

(6) *Pressure.* Although finger tension is a very gross measurement, a noticeable alteration of pressure (whether harder or softer) denotes major pathology.

(7) *History.* Acute bacterial conjunctivitis is highly contagious and will often be reported in the patient's friends. Glaucoma has a strong hereditary tendency.

(8) *Response to therapy.* Failure of acute conjunctivitis (whether bacterial or allergic) to respond to adequate therapy within 3 to 4 days should cast serious doubt upon the accuracy of

DIFFERENTIAL DIAGNOSIS OF THE RED EYE

	Acute Conjunctivitis	Acute Iritis	Acute Glaucoma	Corneal Ulcer or Trauma	Scleritis	Episcleritis
Only superficial vessels	YES					
Superficial & deep vessels		YES	YES	YES	Diffuse	Sector
Pupil	Not affected ! !	Small	Lg., shallow A.C.	Small if 2° iritis	Small if 2° iritis	
Increased pressure		May have 2° glaucoma	Marked			
Opacity	Cornea uninvolved !	Iris & A.C. may be hazy	Steamy cornea	Corneal opacity fluorescein staining	May encroach on cornea	
Ocular discharge	YES			YES		
Decreased vision	NO ! !	YES	YES (Rainbows)	YES		
Severe pain			YES (Vomiting)	YES		
History	Contagious	Often recurrent	Often hereditary	Often trauma	Often Arthritis	
Therapy	Antibiotics	Atropine Cortisone	Pilocarpine Diamox ? Surgery	Antibiotics	Systemic & Topical Cortisone	Topical Cortisone
Prognosis	Self-limited 3-5 days	MAY BE EXTREMELY SERIOUS WITHOUT PROPER TREATMENT				Self-limited 2-4 wks.

diagnosis. Such cases require complete and careful re-evaluation.

The differential diagnosis of conjunctivitis, keratitis, episcleritis, scleritis, iritis, and glaucoma is concisely outlined in the appended table 1.

The following features may be of help in suggesting certain etiologic factors in conjunctivitis:

(1) Associated marginal blepharitis is quite commonly due to staphylococci.

(2) Pseudomembrane formation occurs in streptococcal and diphtheritic infection.

(3) Chemosis indicates very severe infection, such as that produced by the gonococcus.

(4) Scarring never forms with ordinary conjunctivitis, but is very characteristic of trachoma.

(5) Preauricular adenopathy is caused by virus infection or granulomatous bacteria.

(6) Ulcerated nodules suggest the granuloma-producing organisms such as tuberculosis, lues, tularemia, lymphogranuloma, leptothrix.

(7) Flattened papillae and a milky edema are associated with allergy.

It should not be assumed that a red eye heralds only local disease. Classic examples of systemic disease with ocular hyperemia include trichinosis, thyrotrophic exophthalmos, herpes zoster, acne rosacea, sarcoid, brucellosis, avitaminosis, orbital extension of neoplasm, sinus disease with orbital inflammation, Sjogren's syndrome, Bell's palsy, et cetera.

To summarize, redness of the eye may be produced by a great variety of conditions. A number of diagnostic features have been outlined. Glaucoma and scleritis, often also iritis and keratitis, deserve ophthalmologic referral.

Methods of Reporting Cytologic Findings

The cytologic method is now commonly used as an aid in cancer diagnosis. Although this method was first described about a century ago, it was relatively neglected until the past 10 years. The pathologist may report the findings of his examination in various ways. One of the most frequently employed methods of recording the results is the classification system of Papanicolaou.

Class I: Absence of atypical or abnormal cells.

Class II: Atypical cells but no evidence of malignancy.

Class III: Cells suggestive of but not conclusive for malignancy.

Class IV: Cells strongly suggestive of malignancy.

Class V: Cells conclusive for malignancy.

Thus, Class I and Class II are negative. Class IV and Class V are positive, and Class III is doubtful.—Frank Vellios, M. D., Indianapolis: *J. Indiana State M.A.*, 49:408, April 1956.

Franklin County Pelvic Cancer Delay Committee Report

By JOHN H. HOLZAEFFEL, M. D.
Columbus, Ohio, Chairman

The Franklin County Pelvic Cancer Delay Committee meeting was held May 20, 1956, at 12:00 o'clock noon at the Columbus Health Center. Three cases were presented.

Case 23: An 83 year old female, who in 1951, noticed a mass on right labia. Five months later she saw her physician who referred her to a radiologist. He cauterized the lesion and treated area with local radium. In March, 1954, she had a recurrence. Specimen was taken for biopsy with report of epidermoid carcinoma. Treated with radium. In April, 1955, she was hospitalized; treated with radium for local recurrence. April, 1956, patient noticed a mass in right inguinal area. Saw gynecologist and was operated upon with a radical dissection of right lymph and iliac nodes. Squamous cell carcinoma was found in the right groin and all lymph nodes.

Comments: DR. Z. J. R. HOLLENBECK: There should have been a biopsy of specimen at time of first visit. Lesion should not have been cauterized. A biopsy should have been performed and a radical vulvectomy done.

DR. J. H. HOLZAEFFEL: Five year delay on the part of the physician.

DR. J. C. ULLERY: Patient delay of five months.

DR. H. E. EZELL: Delay on the part of the patient is likely to be longer in carcinoma of the vulva due to the modesty of the elderly patient.

Case 24: A 60 year old white female had symptoms of vaginal spotting and bleeding in November, 1954. Saw her physician in January, 1955. No pelvic examination was done and patient was told not to worry. Returned to physician in November and demanded a pelvic examination. He treated her for varicose veins and gave her hormones. Returned to physician 10 days later and he noticed a tender area just inside the vaginal orifice and she was referred to University Hospital. On dilatation and curettage diagnosis was adenocarcinoma of the uterus, involving the Bartholin gland with metastasis to vagina and inguinal lymph nodes. She was seen in February, 1956, and treated with cobalt beads. This was followed by implant of needles into metastatic area, region of the right Bartholin gland; followed by hysterectomy and node dissection in right groin.

Comments: DR. H. E. EZELL: Two month patient delay; 13 month physician delay.

Case 25: A 77 year old white female who in 1942 had a radical mastectomy for carcinoma of right breast and in 1953 a mastectomy for carcinoma of the left breast. No pelvic examination since 1942. Two weeks prior to admission on April 14, 1956, patient had slight amount of vaginal bleeding. She saw her physician who referred her into the hospital. Pelvic examination revealed left adnexal mass approximately 5 cm. in diameter but it was not determined whether this was a uterine mass or left ovarian mass. Laparotomy revealed gross adenocarcinoma implants along lateral wall and left pelvic wall. The implants were dissected and diagnosis was papillary serous cystadenocarcinoma.

Comments: DR. HOLZAEFFEL: Fourteen year delay on the part of physician who did no pelvic examination in spite of the fact he was seeing a patient who had breast carcinoma.

The Etiology of Rupture of the Stomach In the Newborn

HARVEY H. MUSSER, M. D.

THE occurrence of three cases of a novel condition within a short period in a single hospital may not in itself justify a reporting; but when these cases seem to supply an as yet unrecognized or unemphasized solution to the problem of etiology, the following report would appear in order. It is regretted that for reasons good and sufficient to all concerned we are not permitted to report two additional cases from another hospital in this community which presented the identical clinical pattern and in which both the obstetricians concerned and the pathologist are fully convinced that gastric rupture was produced by pneumatic pressure from within the viscus.

HISTORICAL

The literature upon this subject is now extensive but confusing as to etiology. Up to the year 1934 the available reports are concerned essentially with true ulcer, gross traumatism, and perforations above (cephalad) congenital defects such as stenosis and atresia. Few, if any, of these are strictly neonatal. The case reported in 1923 by Lee and Wells³ as "Perforation in Utero of a Gastric Ulcer" can probably be fitted into the general pattern by making allowance for the late appearance of symptoms and the long survival which is known to occur in perforation or rupture of the posterior wall with limitation of the contamination to the lesser peritoneal sac.

Dunham and Goldstein¹ appear to have been the first to emphasize the neonatal element. Among others, Stern, Perkins and Nesse, also Tudor, and Smythe⁶ have reported material that seems to have been truly neonatal. It was Herbut² in 1943 who first attempted to explain the condition upon the basis of a "congenital defect in the musculature." Pendergrass and Booth⁴ in 1946 were the first to point the finger of suspicion at what we now believe to be by far the most common mechanism when they called attention by the use of italics to the fact that their infant had "received intratracheal oxygen" for approximately 5 minutes. Even the distribution of the lesions, which show a predilection for the curvatures at or near the points where the vascular trunks penetrate the submucosa, suggests an internal pressure effect comparable to that seen in diverticulosis.

Other writers such as Wright and Scott, Tow and Ross, Greene and Gose, and Ross, Hill and Haas are noncommittal. Gottlieb, Chu and Shar-

The Author

● Dr. Musser, Akron, consultant emeritus, division of general and abdominal surgery, Children's Hospital and St. Thomas Hospital; consultant, division of general and abdominal surgery, Citizens Hospital, Barberton.

lin speak of a "perforation surrounded by a necrotic ulcer" (probably the description given by the surgeon) although the pathologist tactfully fails to elaborate upon the ulcer and lists the case as one of intracranial hemorrhage and peritonitis. This report fails to contain a statement as to exposure to oxygen although, with an intracranial injury of this severity, there is every reason to believe that oxygen had been given. The mechanism of traumatism to the gastric mucosa by tubes used for aspiration or gavage as suggested by Potter⁵ is logical and should be considered in future studies. More recently Braunstein and possibly Foman, Lowe and DeLeeuw seem to support the mechanism advocated by Herbut.²

CASE REPORTS

Case 1: Full term 5 pound 6½ ounce white male born September 9, 1950, in an Akron Hospital by low cervical cesarean section. The mother, a Para I gravida III, was delivered by elective section because of a previous section for cephalopelvic disproportion. Preoperative medication consisted only of 1/150th grain of atropine and the anesthesia was a combination of ether and cyclopropane.

The infant is described as normal in appearance although the use of a mechanical resuscitator immediately following birth is recorded on the transfer sheet. This infant is described as eating well during the first 4 days with passage of normal stools and adequate intake of a formula. On the fifth day he developed abdominal distention with vomiting and became jaundiced. There was also cyanosis and shallow breathing. Intubation by means of a Levin tube was attempted with some success. A flat film of the abdomen taken at this time revealed fluid in the abdominal cavity as well as a certain amount of gas within the small intestines.

Laparotomy performed 6 hours after admission and approximately 5 days after delivery revealed a large perforation on the greater curvature with diffuse peritonitis. The rupture was repaired but the infant ran a progressively downhill course and expired 6 hours later. Autopsy revealed a perforation measuring 3 cm. in length located near the greater curvature in the upper third of the stomach with advanced diffuse peritonitis.

Submitted March 30, 1955.

Sections from the edge of the perforation showed little or no repair with extensive separation and thinning of the seromuscular coat.

Case 2:* A 6 pound 4 ounce white female infant born at term May 30, 1951, in a nearby hospital. The child is described as normal in appearance and delivered by normal labor from a Para II gravida III mother. Demerol,[®] 100 mg., was given during the course of labor and the delivery was accomplished during the second stage under drop ether. Respirations are described as being delayed so the infant was given caffeine sodium benzoate, and alpha-lobelin. As spontaneous breathing had failed to occur after 10 minutes, the nasopharynx was aspirated by suction and a mechanical resuscitator was used. Following this therapy respirations became gasping and the color seemed to improve so long as the use of oxygen was continued.

Thirteen hours following delivery this infant was transferred to Children's Hospital with poor color and difficult respiration. On account of the predominance of pulmonary symptoms, she was admitted to the thoracic service with a diagnosis of left pneumothorax and possible congenital defect of the heart. X-rays of chest taken shortly after admission were interpreted as a tension pneumothorax involving the left chest. This infant expired 30 minutes after admission and autopsy revealed essentially a congenital diaphragmatic hernia involving most of the left chest complicated by a traumatic 3 cm. rupture of the stomach in the fundic region.

The stomach was found to lie entirely within the abdomen with the ragged area of rupture closely approximated to a 3 cm. defect in the left leaflet of the diaphragm. Sections from edges of the gastric rupture were reported by our pathologist as showing thinning of the muscularis similar to the "congenital defect" described by Herbut.² There was also widespread lobular pneumonia, peritonitis, and bilateral hypoplasia of the kidneys.

Case 3:** The elder of two identical female twins was admitted to Children's Hospital on June 11, 1954, about 2 o'clock in the morning. She was born June 6, 1954, in a nearby general hospital. Mother was gravida IV Para III with uncomplicated spontaneous delivery of a well developed infant weighing 5 pounds 1¾ ounces after a 12 hour labor. The infant is said to have cried immediately after birth but to have become lethargic during the following two days. Two or three loose yellowish-green stools were passed daily while a patient in the other hospital, and it is noted that on the day before transfer there was a sudden rise in temperature to 102.2°. No abdominal distention is recorded in the transfer sheet, and there is also a statement in this sheet that no mechanical resuscitation had been attempted.

Examination after admission to Children's Hospital showed moderate distention of the abdomen with prominence of the usual venous pattern over the abdomen and chest. The wall was tense and there was complete absence of bowel sounds to auscultation. No abnormal abdominal masses and no unusual intestinal patterns could be demonstrated. X-ray examination a few hours after admission was reported as showing an accumulation of air beneath the

diaphragm, in the upper left gutter, and also in the pelvis.

Laparotomy was performed about 8:05 a.m. on the day of admission. In the operative record it is noted that a large amount of air escaped from the abdominal cavity on opening the abdomen. The abdominal cavity was filled with purulent material and there was a large mass of milk curd in the left upper quadrant. Further exploration revealed a 1 cm. perforation of the stomach located upon the lesser curvature at a point 3 cm. below the diaphragm. This perforation was closed appropriately using Lembert sutures of silk and the milk curd was removed completely by "scooping with the hands." The fluid and exudate were then removed by suction and the incision closed appropriately without drainage. The infant died about 8 a.m. on June 14, 1954, as a result of the peritonitis but no autopsy was permitted. The operating surgeon has been reliably informed that this infant had received oxygen soon after delivery by way of a tightly fitting rubber mask supplied by tubing directly, and without a reducing valve, from one of the standard gas cylinders.

ANALYSIS OF SUGGESTED CAUSES

It is believed that the preferred solution is the one suggested by Pendergrass⁴ and that it is unnecessary to postulate a "congenital defect of the gastric musculature." Personal review of the photomicrographs of Herbut² and others is unconvincing in that the condition described is painfully reminiscent of that seen following mishandling of severely distended intestine and in pneumatic rupture of the large bowel. In both of these last conditions there is seen widespread separation of the seromuscular layer upon the submucosa associated with apparent thinning of the muscularis as is also shown clearly in the photomicrographs of Lee and Wells.³ It is my considered opinion that the incidence of this condition runs closely parallel to the therapeutic use of oxygen under pressure and I find it unnecessary to introduce a factor previously unrecognized in the newborn child.

In the group of cases associated with the use of a tight-fitting mask, it is not altogether clear why at times pressure within the system leads to rupture of the pulmonary apparatus and at other times to rupture of the stomach. It is quite possible that the explanation lies in what physicists call the rubber-bag phenomena in which periodic introduction and release of gas through a tube or diaphragm of appropriate size finally results in distention and rupture of the bag. Experimental study of this mechanism, preferably by physiological methods, would appear indicated.

MANAGEMENT AND PROPHYLAXIS

Management of the condition is obvious. Salvage by surgical intervention will depend upon the early diagnosis and will vary inversely as the interval between rupture and surgical repair and also inversely as the size of the rupture.

Prophylaxis of the condition can be effected

*Reported by permission and with the endorsement of Dr. W. H. Falor.

**Reported by permission and with the endorsement of Dr. R. T. Allison.

by (1) more critical use of oxygen therapy in the newborn; (2) specialized training for all personnel engaged in the operation of respirators, resuscitators and the like; (3) the introduction of an appropriate reducing valve in all closed systems where gas is administered by way of a closely fitting face mask or a catheter; and (4) complete elimination from the delivery room of certain types of mechanical resuscitators which have proven to be difficult to keep in proper adjustment and others which permit the building up of high pressures even though maintained in adequate adjustment. If these observations and opinions are confirmed by others, it is suggested that the condition be described as pneumatic rupture of the stomach in the newborn.

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Allergic Problems Often Confront Specialist in Ophthalmology

The ophthalmologist encounters allergic problems frequently. Seasonal and nonseasonal simple allergic conjunctivitis are common. Contact dermatitis of the lids is not uncommon and the eye specialist must realize that the mechanism of this allergy is one of delayed sensitivity, and that the diagnostic procedure is the patch test.

Vernal conjunctivitis, with its seasonal trend, the large number of eosinophiles in the exudate, and the relief in certain environments, speak for its allergic character. And yet the nature of its allergy is more or less a mystery and constitutes a challenge to the specialty of ophthalmology.

Lens opacities in the young adult with generalized atopic dermatitis is an allergic problem and the allergic management following recognition of its true nature may prevent full cataract formation.

There is no doubt that such conditions as sympathetic ophthalmia, iritis, iridocyclitis, and uveitis can be of allergic origin, either due to infectious allergy or to a process of sensitization to one's own tissues. This is a field deserving considerable co-operative and investigative interest on the part of the ophthalmologist and allergist.—Samuel M. Feinberg, M. D., Chicago: *Illinois M.J.*, 109:129, March 1956.

The Story Behind the Word

Some Interesting Origins of Medical Terms

Intestine—When a little boy refers to his intestines as his "insides," he is literally correct. For our word intestine came from the Latin word "intestinus," meaning inward or hidden, which in turn comes from the Latin "intus" or within. Hence the term simply means "insides."

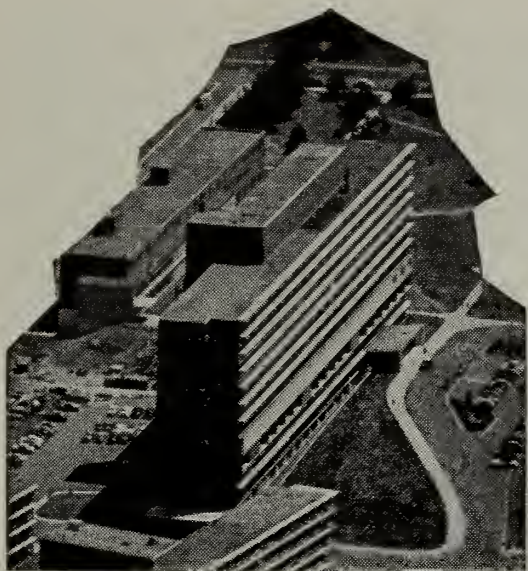
Nostrum—From ancient times to modern days, charlatans and quacks have foisted panaceas and "cure-alls" upon a gullible public. Each and every one of these supposedly potent and miraculous remedies is of a secret composition, the makers claiming it is "our own" medicine and they always claim to have exclusive possession of the formula. Because of this, quack medicines have been called nostrums, which literally means "our own." The word nostrum is the neuter form of the Latin word "noster" or ours. The word came to be used in English during the sixteenth century.

Cacao—A term derived from the Spanish via the Mexican Nahuatl word "cacahuatl" meaning "the seed." The term denotes the seeds of the chocolate tree, *Theobroma cacao* from which cacao butter, chocolate and cocoa are prepared.

Calamus Scriptorius—This is the name applied to the lowest angle of the fourth ventricle of the brain and was so called because it is shaped somewhat like a pen point. The term literally means a reed-pen such as the ancients used for writing. It is derived from the Latin "calamus" or reed, plus "scriptus" or written. This anatomical structure was described and named by Chrysippus of Cnidos in about 340 B. C.

Caduceus—This is the symbol or insignie of medicine. The true caduceus consists of the staff of Aesculapius about which is entwined a single serpent. The Medical Corps of the United States army uses as an insignie a double winged staff with two serpents entwined about it. This is really the wand or staff of Hermes or Mercury, the mythological winged messenger of the gods. The word "caduceus" is derived from the Greek word "kadukion" meaning "a herald's staff" and this in turn comes from the Greek word "kedux," or herald. Serpents have since ancient times been used as a symbol of healing and this is possibly due to the fact that the snake sheds its skin and this has been considered as a renewal or healing process. Also, according to Greek mythology it was a serpent that brought to Aesculapius, the legendary god of medicine, a special herb possessing great healing powers. The "caduceus" was supposedly first used as a medical emblem by Johann Froeben a sixteenth century medical book publisher as a title page design.

—HARRY WAIN, M. D., Mansfield, Ohio.



A Case Record

From The University Hospital,
Columbus, Ohio

Edited Under the Auspices of the Ohio Society of Pathologists

Philip Wasserman, M. D., President

Presented by Philip T. Knies, M. D., and Emmerich von Haam, M. D.

Edited by Dr. von Haam

PRESENTATION OF CASE

THIS 49 year old colored male was found to be hypertensive on a routine physical examination 9 to 10 months before death. He soon began to have dizziness on exertion and later developed severe headaches, followed by weakness, easy fatigability, anorexia and a 20 pound weight loss. He noted dull nonradiating paraumbilical pain not related to meals, had tarry stools and a decreased urinary output. Six years previously he had had a cerebral vascular accident with transient right hemiplegia. There was no family history of hypertension.

He was first admitted to University Hospital 3 months before his final admission. At that time he had a blood pressure of 220/160, marked arteriolar spasm of the retinal vessels with recent and old exudates and fresh hemorrhages in the retinae. Papilledema was absent. The heart was moderately enlarged. The urine contained 640 mg. of protein and variable numbers of red blood cells. The blood urea nitrogen averaged 50 mg. and the creatinine 4 mg. A 2-hour phenolsulfonphthalein test showed 25 per cent excretion of the dye. The renal plasma flow was 74 cc., the renal blood flow 104 cc., and filtration rate 24 cc. per min. with a filtration fraction of 0.32. Ansolysen,[®] apresoline,[®] serpasil,[®] digitalis and prostigmin[®] were prescribed together with low sodium diet. The blood pressure stabilized at about 160/110. The weight rose from 112½ to 123½ pounds. He received three blood transfusions. He was discharged after a month's stay in the hospital, was told to "cat no salt" and was continued on the same medications. When the patient visited the clinic 11 days after his discharge he was edematous and dyspneic; diuretics and diet were prescribed. However, during the ensuing 3 weeks the blood pressure

rose again to 240/120, he developed diarrhea and severe anorexia, and was readmitted.

PHYSICAL EXAMINATION

The patient was emaciated, dehydrated and lay quietly flat in bed. His pulse was 84 and his blood pressure 260/160. Hypertensive retinopathy was present, papilledema absent. There were scattered rales in the lung bases. The left heart border was in the anterior axillary line at the sixth interspace; no murmurs were heard. The abdomen revealed minimal generalized tenderness. There was slight edema of the feet, hands and pretibial areas. Neurological examination gave no significant findings.

LABORATORY FINDINGS

The admission blood count showed 7,620 white blood cells with 84 per cent neutrophils and 15 per cent lymphocytes; 4.1 million red blood cells and a hemoglobin of 11.9 Gm. The specific gravity of the urine varied between 1.005 and 1.012, the protein content from 50 to 480 mg., granular casts from 0 to many, and there were a few white blood cells and 0 to 20 red blood cells per high power field. On admission the blood urea nitrogen was 56 mg., creatinine 3.0 mg., inorganic serum phosphorus 4.7 mg., the CO₂ combining power 39 vol. Sodium and chloride were normal, potassium 3.6 meq. The A:G ratio was 2.8:2.7, alkaline phosphatase 17.7 units, the prothrombin time 25.5 per cent. Thymol turbidity, bilirubin content and serum cholesterol were normal.

About three weeks before his death the stools became guaiac-positive and the red blood count fell to 2.7 million, the hemoglobin to 8.9 Gm. Terminally the blood urea nitrogen rose to 107 mg. and creatinine to 5.2 mg. The electrocardiogram revealed an incomplete left bundle branch block and a possible old lateral infarction.

Submitted May 17, 1956.

ROENTGENOGRAPHIC EXAMINATION

The chest plate taken on his first admission showed a heart approximately 30 per cent enlarged in its transverse diameter. The cardiac enlargement was mostly of the ventricular salient and mostly on the left. There was a straightening of the upper left ventricular border, which may indicate myocardial fibrosis or the result of an old coronary occlusion. The ascending aorta appeared tortuous and some calcification was seen in the descending aorta.

The film taken two months later showed more pronounced enlargement of the heart, with the transverse diameter increasing from 160 mm. to 185 mm., and the enlargement was now not left ventricular alone but an enlargement in which all chambers participated. Both lungs showed increased markings at the base, which was interpreted as a small amount of interstitial fluid or chronic fibrotic changes.

HOSPITAL COURSE

In 10 days his weight increased from 120 to 137 pounds, there was no fever, and his urine output was fair. The systolic blood pressure ranged from 210 to 260, the diastolic from 120 to 160. In spite of intravenous mercurials the edema persisted and ascites developed, necessitating paracentesis. He also received fluids, 500 cc. of serum albumin, 2,000 cc. of packed red cells, digitalis, sedatives, hyponotics, laxatives and penicillin. He became semistuporous, irrational and incontinent of stool and urine. All medications except sedatives were stopped two days before his death. He developed Cheyne-Stokes respirations and died 30 days after his second admission.

CLINICAL DISCUSSION (PART I)

DR. P. T. KNIES: Unless the old fox has a trick up his sleeve that I am not aware of, this particular case presents few problems from a diagnostic standpoint. After you have read as far as about the ninth or tenth line you will realize that we deal here with a case of severe hypertension. Apparently at first he had not been sufficiently ill to seek the care of his doctor and his high blood pressure was discovered on an incidental examination. However, he soon developed the classic complaints of hypertension, including the very important symptoms of general weakness and easy fatigability.

Six years previously he had had a cerebral vascular accident with transient right hemiplegia. Of course hemiplegia does not only occur with hypertension, and I can't say exactly how much more common it is in the presence of hypertension than without it, but certainly a good many patients become hemiplegics through an episode of hypotension complicating an otherwise smooth clinical course of hypertensive disease. So the inference is that he was probably hypertensive at least six years before his death.

When he was first admitted to this hospital his diastolic blood pressure was 160, and examination of his fundus revealed severe pathological changes which would be classified as Keith-Wagner III. The urine examination indicated unquestionably a bleeding renal lesion, and on at least one occasion the urine was loaded with red blood cells. The renal plasma and blood flow were reduced about 90 per cent, and so were the filtration rate and the filtration fraction. Consequently there was at that time evidence of very severe damage to renal function, indicating that the injury to the kidney was a diffuse one and not limited to one kidney or a portion of one kidney.

The medication, which was quite extensive, succeeded in stabilizing the blood pressure at about 160/110. I believe it is correct that during that hospitalization he was not particularly anemic. However, during the ensuing three weeks the blood pressure rose despite the medication to 240/120 and he developed diarrhea with severe anorexia.

PHYSICAL EXAMINATION

The physical examination at his second admission showed a considerable cardiac enlargement, raising the question of left heart failure. He still had some persistent signs of his old hemiplegia. Granting that this man was somewhat dehydrated, a red blood count of 4,100,000 and a hemoglobin of 11.9 Gm. are not found with a chronic glomerulonephritis in uremia, they are not the figures of advanced primary renal damage. The urine specific gravity varied between 1.005 and 1.012, although on his first hospitalization a specific gravity of 1.024 was recorded, which again is evidence that we are not dealing with primary renal disease.

In that respect let us go back to one of the patient's complaints. I believe even on the first admission, and certainly at the second and in the outpatient clinic between the two, he complained of abdominal distress and diarrhea. I am not prepared to say what ansolysen® and serpasil® might do to a person's intestinal action. Certainly flatulence would be one thing that would be anticipated. It is, however, possible that severe atony of the sphincter could be produced and interpreted as diarrhea. On the other hand, with rising nitrogen retention one must anticipate the possibility of a uremic serositis, which may be in the form of a peritonitis, a pericarditis or a pleuritis.

Later his stools became guaiac-positive and the red blood cells fell to 2,700,000. In other words, he obviously had gastrointestinal hemorrhage and consequently developed a hemorrhagic enterocolitis which would be a very common feature of either nephritis or malignant hypertension with uremia. The potassium fell to 3.1 mEq. and the blood urea nitrogen was terminally 107 mg. and the creatinine 5.2 mg. A very great

deal of emphasis is placed in some places upon the value of creatinine determination as compared to the blood urea nitrogen. By the time the creatinine values begin to rise, I don't believe that there is any question about what the clinical situation is. The blood urea nitrogen seems to me to be an adequate indication of nitrogen retention, while creatinine determination may seem a better terminal test. Certainly it is not a better early test.

Intravenous mercurials were given with the rather faint hope that the kidneys, which were unable to eliminate adequate fluids, might be forced to do that. Inasmuch as this individual was on my service, I can assure you that this was a desperation measure with little anticipation of benefit and with the feeling that there was nothing to be lost. Ascites developed. He became semistuporous, irrational, developed Cheyne-Stokes respiration and died after a hospital stay of one month.

NATURE OF HYPERTENSION

There appears no reason to doubt that this patient had malignant hypertension. We use that term as though it were a separate disease, and at least I am going to present the Knies tenet that it is not a separate disease. Again Dr. von Haam may disagree with me very markedly, but I cannot tell when a process changes from a rather indolent, benign essential hypertension to a malignant hypertension. The only patients who show the malignant phase from the beginning are those who have a chronic glomerulonephritis. This condition seems to have an implacable progress that does not brook any regression. But all others appear to have a longer or shorter transition period between benign essential hypertension and malignant hypertension, and I think this condition should probably not be thought of as a separate disease but as a stage, or rather a degree of intensity, of the disease. I think I will be in a position to demonstrate that to you in the second part of the discussion.

Earlier, I pointed out that by reason of a specific gravity of the urine of 1.024, and after as good a PSP (phenolsulfonphthalein test) as the patient had at this time, with 25 per cent elimination in 2 hours' time, there was reason to feel that the kidney was not the primary site of disease and that this was not a primary glomerulonephritis, which with one or two exceptions seems to be about the only other entity that may give a hypertension as high as this individual had. Oddly enough, there was no mention in the hospital record of one other factor that we must think about in connection with severe hypertension, namely, a pheochromocytoma, keeping in mind that it does not necessarily have to be an intermittent hypertension. We also have to think of a coarctation of the aorta, which will likewise give extremely

high blood pressures through the associated renal changes.

I should also feel that this individual ought to have evidence at autopsy of an old left cerebral infarct probably located in the left internal capsule. As the man had recovered from it to a large extent, so that he was able to return to his work, the infarct was probably not very large. I think also we will find that his kidneys had a necrotizing arteriolar nephrosclerosis resulting in small contracted kidneys. I would estimate that they would together weigh no more than 180 grams. He also had a hemorrhagic uremic enteritis and left ventricular hypertrophy with dilatation.

Terminally, and that is the condition we deal with at an autopsy, he undoubtedly had a passive congestion of both lungs and probably of the liver, although interestingly enough the liver was never found to be palpable. There is no reason to feel that he had a pericarditis, and the level of the blood urea nitrogen was not high enough to make me think that he had one. In summary then my clinical diagnosis would be:

CLINICAL DIAGNOSIS

1. Necrotizing arteriolar nephrosclerosis.
2. Left ventricular hypertrophy and dilatation.
3. Acute hemorrhagic enteritis.
4. Old cerebral infarction.
5. Uremia.

PATHOLOGICAL DIAGNOSIS

1. Necrotizing arteriolar nephrosclerosis.
2. Hypertensive and arteriosclerotic heart disease.
3. Early bronchopneumonia.
4. Necrotizing hemorrhagic enteritis.
5. Cerebral encephalomalacia.
6. Uremia.

PATHOLOGICAL DISCUSSION

DR. E. VON HAAM: Gentlemen, we brought you this case today not because it represents a diagnostic problem. As Dr. Knies has already stated, the diagnosis can be made as soon as you take the blood pressure. To us, it represents however an important therapeutic problem. Therefore, after I have confirmed Dr. Knies's excellent predictions, I will ask him to critically review the therapy. After all, the patient was diagnosed properly and the patient died. Do we have to admit the hopelessness of such a condition, or can we give a little more hope to these cases, and if so, where does this hope lie?

At autopsy his body appeared thin and emaciated, weighing about 115 pounds. He appeared constitutionally not the type which is linked with hypertension. There was some pitting edema of

the ankles, forearms and hands, indicating that he apparently did not have circulatory failure but that this edema was perhaps due to the accumulation of fluids in his body. There was a slight bilateral hydrothorax.

His heart was large and weighed 480 grams. The left ventricle measured 16 to 19 mm. in thickness. The coronary arteries showed evidence of severe arteriosclerosis. The myocardium showed patchy fibrosis of the lateral and apical portions of the left ventricle. The lungs were heavy, congested and edematous. He had a very small spleen and his liver was not enlarged. He had no gallstones. His gastrointestinal tract showed hyperemia, which we often see with uremia. He did not have a severe uremic colitis, but he had small areas of necrosis and hemorrhages in the colon and in the entire gastrointestinal tract compatible with his uremic condition.

The kidneys were not quite as small as predicted. Each weighed approximately 120 grams. They did not have the typical gross appearance of acute malignant nephrosclerosis, which calls for large mottled kidneys with petechiae ("flea bites"), but rather they appeared contracted and finely granular and their cortices measured only 2 to 3 mm. in thickness. This agrees with Dr. Knies's contention that his hypertension was of longer duration than the 9 to 10 months which the history seems to let us believe. His brain was small, weighing only 1100 Gm., and showed several small scattered lesions the largest measuring 1.5 cm. in diameter. Both hemispheres were involved and no distinct thrombi could be recognized. The gross appearance of the brain was typical of hypertensive encephalopathy.

MICROSCOPIC EXAMINATION

Sections through the heart showed small recent areas of infarction together with hypertrophy, patchy fibrosis and marked coronary sclerosis. Sections through the lung showed many alveoli filled with fibrinous exudate and a few leukocytes, indicating an incipient pneumonia. Microscopic study of his gastrointestinal tract revealed severe necrotizing arteriolitis with fibrinoid degeneration and thrombosis. It is the lesion typical of malignant hypertension and now regarded more as a consequence than a cause of his uremic condition. It is the lesion which explains the terrific hypertension of the patient, which now has turned from a functional condition into an organic disease.

Sections through the kidneys showed an advanced arteriolar nephrosclerosis. Many glomeruli appeared still functioning, and I believe that the uremia was partly due to vascular ischemia and not to complete glomerular destruction. Sections through the brain revealed recent and old encephalomalacia typical of hypertensive encephalopathy. The patient never had a mas-

sive stroke. He had several of what we call "little" strokes.

We can then summarize that the autopsy indeed confirmed Dr. Knies's diagnosis. He perhaps had more brain damage than was suspected, but his condition precluded careful neurologic examination. He did die from malignant hypertension involving all the blood vessels and showed finally the lesions which have been explained by uremia. Dr. Knies:

CLINICAL DISCUSSION (PART 2)

DR. KNIES: I think the point is very well taken that the generalized underlying pathology here is arteriolar, and I think that with a blood urea nitrogen no higher than he had I probably should not have predicted that much kidney damage. The more diffuse and multiple brain damage should have been included in the comments.

If you should leave this room with the concept that what you have just heard is the uninterrupted course of hypertension, I think much of the value of this conference would be lost. I would like, therefore, to present the case of a 41 year old woman whom I saw first in 1952, when she had fallen in the bathroom. There had been four such falls in the past six years, usually coming on when she suddenly rose from a sitting or recumbent position. The blood pressure at that time ranged from 170 to 162 systolic and 112 to 110 diastolic. There was a familial history of hypertension. The diagnosis of an essential and comparatively benign hypertension appeared justified.

ANOTHER CASE

This individual moved out of town for a period of time and therefore was first seen by her oculist. Dr. Culler called me in considerable alarm and told me that she had a lesion he classified as Keith-Wagner IV, indicative of malignant hypertension with a very unfavorable prognosis. The patient felt well but was having an increased fatigability and noticed rapid breathing on climbing stairs. The blood pressure now was 234/156 and 246/158. The blood urea nitrogen, which on the earlier examination had been 13, was 56 mg. The left vision had become all lines, figures and fuzziness. Her color vision had been lost. The symptoms then were visual loss, severe headache, shortness of breath, and signs of stiffness and fullness in the abdomen.

We felt in this instance that we had no time to evaluate antihypertensive medication. If we were going to do anything for this individual the time was now, not two to three months from now. Consequently four days later she had her first stage of dorsolumbar sympathectomy. The second stage she had three weeks afterwards. The postoperative convalescence was very satisfactory, the recession of the papilledema beginning in the first stage. On admission the blood pres-

sure readings were 230/160, 238/165, 228/160. At discharge the blood pressures averaged 150/100, 146/108, 154/110, 138/108. I am extremely proud to present to you this afternoon Mrs. —, and I am very sure that the course of Mrs. — would have continued very rapidly and implacably had the situation not been stopped as it was.

SECOND CASE

The second case is Mr. —, a 56 year old man who came to me with extremely severe headache. His blood pressure was 210/140 and 200/138. In spite of all antihypertensive medication I could think of he had a severe progression of his hypertension. At first his response to apresoline® and other drugs of that sort was reasonably good and he could be carried along for a long period of time until he became refractory. We always felt in his instance that the recurrence and the exacerbation of his hypertension were associated with social and domestic difficulties which were quite difficult to manage.

The blood pressures in the last few months ranged between 246 and 210 systolic and 140 to 115 diastolic. He likewise had developed fundi which I would classify as about a Keith-Wagner III. He had exudates, flame-shaped hemorrhages but no papilledema. He became short of breath and his abdomen was distended.

Again we felt that something drastic had to be done, that this man had begun to go bad in a cardiac way, with edema of the ankles and legs, a tremendously enlarged liver, a good deal of pulmonary edema, a great deal of cardiac enlargement, orthopnea, and paroxysmal nocturnal dyspnea. He was admitted to the hospital and had a bilateral lumbodorsal sympathectomy and a bilateral hemiadenectomy. His last blood pressure was 162/96. He lost all his headaches, his edema and shortness of breath disappeared, and he lost 46 pounds.

I would like to emphasize that one of these patients was operated upon at the first sign of beginning renal insufficiency, the other was operated upon in fairly well advanced cardiac failure. The one does not have cardiac failure any more, the other has normal renal function, and that has been our experience with others.

DR. VON HAAM: What are your criteria for selecting patients for sympathectomy? I understand that not all patients have such a successful result.

DR. KNIES: That is right, and I don't know what the criteria of selection ought to be, Dr. von Haam. I have had 36 patients who have been operated upon. Only one of the 36 is not living now. This one developed a coronary attack between the first and second stages of surgery. All the others are living. I have felt that sympathectomy offered these people the best therapy we have at this time. They all

fell into the class where an implacable advance of their disease seemed very probable and for whom I had no medicine that I thought competent to arrest it. Therefore surgery was recommended before the last horse was ready to drop. I have not submitted to sympathectomy any individual who could be controlled by phenobarbital, reserpine, or by the other measures which have been useful.

MEDICAL STUDENT: Do these patients have to continue medication after the sympathectomy?

DR. KNIES: Mrs. — was on no medication for a matter of several months. She is now using moderate medication for a recurrent mild hypertension. Mr. — is not using any antihypertensive therapy at all.

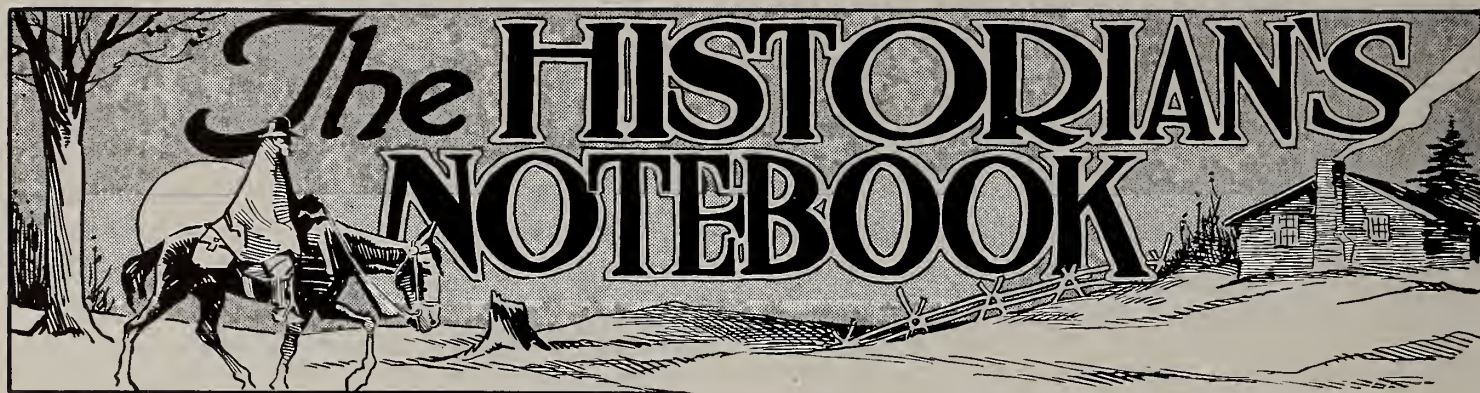
The Value of Hormone Therapy In the Rheumatic Diseases

Suppression of inflammation is the main effect of these hormones, (ACTH, cortisone and hydrocortisone, prednisone and prednisolone) which are the most powerful antiphlogistics at present available. The objective manifestations of joint inflammation, such as tenderness, swelling, redness and warmth of articular structures, usually improve dramatically within a few days of starting adequate doses of any of these hormones. Pain is usually relieved rapidly.

Synovial thickening and joint effusions subside. Biopsies of synovial membrane demonstrate histologically the improvement which can be appreciated clinically. The "acute phase reactants," including the sedimentation rate, C-reactive protein and mucoprotein determinations, reflect the suppression of the inflammation. Systemic manifestations of the inflammatory process, such as malaise, anorexia, weight loss and fever, also improve. In many cases, unfortunately, these effects are incomplete or inadequate in doses which are safe enough for prolonged use, and in other patients a gradual return of symptoms occurs despite continuance of hormone therapy.

Another result of the suppression of inflammation is relief of the spasm of muscles about inflamed joints which is characteristic of acute rheumatoid arthritis. Considerable disability and even deformity may be due to these muscle changes, which can lead to atrophy or contracture. These changes may be avoided by the use of potent anti-inflammatory agents such as the steroid hormones, especially when the relief they afford allows the patient to cooperate with an appropriate plan of physical therapy.

Other manifestations of rheumatoid arthritis which may be beneficially affected by hormone therapy include an acute hemolytic anemia which is occasionally present and the ocular pathology which may be associated with this disease.—Alfred Jay Bollet, M. D., Detroit: *J. Michigan M. Soc.*, 55:278, March 1956.



Dr. Isaac Connor Swett, Rural Physician

By CHESTER P. SWETT, M. D.

IT is interesting to note the reason why a physician of a century ago entered the practice of medicine. Dr. Isaac C. Swett became interested in medicine primarily because of the prevalence of salivation after treatment by doctors of the rural area where he lived. This disagreeable side effect was due to the administration of enormous doses of calomel, although the other mercurial preparations also were offenders. He believed that medicine could be practiced without the use and abuse of calomel. He began to read medicine in 1857. For a time he practiced under the preceptorship of Dr. Townsend of that locality.

Dr. Isaac C. Swett was born on March 17, 1828, in Columbia Township, Meigs County, Ohio. He was one of four children born to Benjamin Leigh Swett and Eleanor Connor Swett, and was a descendant of John Swett of Newbury, Massachusetts. The latter, with his wife and four sons, was admitted to the freedom of the Massachusetts Bay Colony in 1642, after emigrating from England. He was one of the founders of Newbury. His son, Stephen built a house there about 1670 which is still standing.

Dr. Swett's father, Benjamin Leigh Swett, came to Ohio in 1816 with his parents. Isaac attended a country school and helped with the usual work of a growing boy on his father's farm. In 1850 he was married to Rhoda Havener and to this union three children were born. Mrs. Swett died in 1859. Dr. Swett married Mary Bobo in 1861. Four children were born of this marriage. As previously stated, Dr. Swett began to read medicine in 1857. His main livelihood, however, continued to be gained by farming. After serving under Dr. Townsend for some time, he began to make calls in the capacity of an attending physician.

MILITARY SERVICE

Dr. Swett enlisted as a private in the 116th O. V. I. on August 15, 1862, to serve for three

The Author

● Dr. Chester P. Swett, Lancaster, former member of The Council of the Ohio State Medical Association, is a practicing physician in Lancaster, a member of the staff of Lancaster-Fairfield Hospital, and Director of Ohio Academy of General Practice.

years. The regiment spent the winter of 1862-63 in training in West Virginia, then northern Virginia. In the spring of 1863, the regiment was merged with other units under the command of General Milroy. This force occupied Winchester, Va., in May 1863. Late in May, Dr. Swett contracted measles and was quite ill for three weeks or more. It is likely that he had bronchopneumonia as a complication. Since the nursing facilities were so very meagre, he wrote Mrs. Swett that he was ill, asking her to come to give him nursing care. She immediately made the trip to Winchester and began to administer bedside care of which he was so sorely in need.

Momentous military events were shaping up. As a part of General Lee's maneuvers leading to the Gettysburg campaign he detached a sizable force under General Ewell to attack Winchester. The attack was pushed with great vigor and spirit. Winchester was almost surrounded and General Milroy was forced to evacuate the town. During the evacuation a considerable number of Union soldiers were captured, including all the sick and wounded.

When the Confederate army entered the town, June 15, 1863, Dr. Swett was still convalescing in a hotel which had been commandeered for use as a hospital. Mrs. Swett was with him. As they were on the second floor they hoped that the search would not be very thorough. However, they were discovered and taken prisoners. Mrs. Swett was taken to a house where all the

Submitted April 27, 1956.

wives of the Union officers and of enlisted men, along with civilian personnel and camp followers had been placed in custody, were assembled. They were soon put on trains for Richmond.

Among those on the train with Mrs. Swett were the wife of Colonel Washburn, Chaplain Brady, and Elmer Armstrong, the sutler of the regiment. Since some of the track had been destroyed by Union cavalry they had to walk part of the trip. At Richmond, the women were imprisoned in Castle Thunder.

Dr. Swett was also sent to Richmond a day or so later, although he was still very weak. He was held in Libby prison. He had had no news of his wife's fate since their capture. In a few days, however, he received word of her whereabouts, relayed through the efforts of Mr. Armstrong, and also learned that she would soon be released. This intelligence was secured in the following manner:

Mrs. Swett was held on one of the upper floors of the prison. Through the grapevine she learned that Mr. Armstrong was on the first floor and that he was permitted to leave the prison on parole at times. A sutler had a quasi-military status and was a noncombatant. Mrs. Swett wrote a note and lowered it by string from a window to the first floor. The note was detached by a prisoner below and given to Mr. Armstrong. The latter managed to relay the message to Dr. Swett.

MRS. SWETT RELEASED

According to the records of the War Department, Mrs. Swett was paroled at City Point, Virginia, July 2, 1863, and reported at Camp Parole, Maryland, on July 3, 1863, in the company of some other ladies who were captured at Winchester. They were returned to Washington, where they rested several days as guests of the government. They were taken on a tour of the city and afterwards returned to their homes. Mrs. Swett did not know at this time when she would see her husband again.

After the war, Mrs. Swett was offered a reimbursement by the Federal Government. She declined it with thanks, stating that she had enjoyed the episode so much and did not feel that she should receive payment for exciting memories. This attitude is scarcely understandable at the present time. Nevertheless, it is refreshing to learn that the ordinary citizen of a hundred years ago did not desire help from the government when no disability was incurred. Mary Swett Tent, Daughters of Union Veterans in Glouster, Ohio, was named in her memory.

Mrs. Swett had two brothers in the Union Army. One was a captive for 18 months, part of which time was spent in Andersonville prison. He lost about 60 pounds but was hearty enough to live for 50 years after his release.

Dr. Swett was exchanged on July 15, 1863, and

as soon as he returned to his regiment, was given a furlough. At the end of the furlough Dr. Swett returned to his regiment which was assigned to the army of the Shenendoah under General Sheridan. He served through the remainder of the war. This embraced all the campaigns in the Shenendoah Valley in 1864, including the battles of Cedar Creek, Fisher's Hill and Opequon. His division was transferred to the Army of the James in December 1864, as a unit of the 24th Corps. This army served around Petersburg and was active through the winter and spring of 1865. After General Lee evacuated Petersburg the 5th and 24th Corps were hurried forward by General Sheridan. He maneuvered them across the road to Lynchburg at Appomattox, which led to the surrender.

Dr. Swett was mustered out of the service in Richmond, June 14, 1865. When discharged he was listed as being 6 feet 1½ inches tall, of a light complexion, and his occupation was recorded as a physician. He wore a heavy beard which he described as being, "as red as a fox's tail." He returned home to resume farming and to practice medicine. His office continued to be in his farmhouse. This really was a rural practice, since the nearest village was about five miles distant.

An understanding of the economics of a rural medical practice of 90 years ago is worthy of a brief comment. The income of a doctor who devoted all of his time to the profession was quite small. Probably Dr. Swett was more aware of this than anyone else, after he had practiced for a while. He prudently established himself as a farmer and used the farm to subsidize his practice. As his practice increased, he hired men to do the farm work and managed his farm along with his practice. He apparently enjoyed the practice of medicine since he could have made a living without it. As time passed he became known as a doctor rather than a farmer.

ATTENDED MEDICAL LECTURES

In order to improve his knowledge of medicine he attended lectures each year for a number of years at Cincinnati, nearly always at the Eclectic Medical College. He evidently favored the Eclectic materia medica since it did not feature the use of heavy metals. After he had attended the medical courses which included materia medica, he prepared some of the drugs which he used in his practice. Infusions, fluid extracts, syrups, and tinctures were made in his home. Pills and powders were regularly prepared in his office. He was of necessity his own pharmacist since the corner drug store was 15 miles distant. Toward the end of his active practice, the more hardy and determined drug salesman began to call on him.

Mrs. Swett accompanied him on many of his maternity cases. She hired a girl to do the

housework and cooking so that she could be away from home frequently. She also administered bedside nursing care to the best of her ability. There were instances of a patient being brought to the office desperately ill. In such cases the doctor had a bed prepared in his home. Mrs. Swett gave the patient nursing care, while Dr. Swett treated the patient until his condition permitted transportation to his home.

Actually, a doctor who practiced at that time in a rural community was not nearly as busy as a doctor in a similar community at the present time. Maybe he would see six or eight patients a day. The trivial illnesses and many minor injuries were treated by some member of the family. When a doctor was called to see a patient, he could depend on it that all the home remedies had failed.

The drugs which were effective were few. Patients were justifiably skeptical of the doctor's drugs. Thus, the doctor found it imperative to instill in the patient, faith and confidence in his ability to cure him. This was accomplished by various means. The personality of the physician could of itself smooth the precarious path to recovery.

Some doctors assumed a pontifical manner, calculated to impress the whole family. Very intricate, complicated and careful instructions were given by some doctors concerning the administration of medicines. This method seemed to impress the various members of the family. If, with the next visit the patient had become worse and a careful step-by-step review of the instructions revealed an error or two, the reason for the condition of the patient was pointed out.

PATTERN OF DISEASES

The diseases occurring then differed considerably from those prevalent today. In the summer, typhoid fever was endemic. The diarrheas of infancy and early childhood, known then as cholera morbus and cholera infantum, reaped a grim harvest. Malaria was not uncommon in southern Ohio then. The hill farms comprised the choice parcels of lands. There were many swamps in the bottom lands. The people knew that those who lived in the bottoms were more likely to contract the "ague" or chills and fever.

In the winter, the respiratory diseases were prevalent then as now. Pneumonia was frequently fatal. The contagious diseases of childhood were particularly virulent. Measles and scarlet fever were especially serious. The doctor made a diagnosis by means of his five senses and unaided by any laboratory studies. However, the doctors of that era often developed their senses to a high degree of efficiency.

Dr. Swett did not hesitate to extract a tooth when the patient requested it. This was done without the benefit of an anesthetic. The pa-

tient submitted to the ordeal with what fortitude he could muster.

The doctor also served in the capacity of a veterinarian. The chances are that he didn't know much more about veterinary medicine than the farmer. However, at times he would be called to treat a sick animal. It was usually a one-treatment affair. If that failed to put the animal on its feet, no more money was spent. The reason for such versatility on the part of the doctor was that no dentists or veterinarians were available.

A HOBBY IN HORSES

Dr. Swett was very fond of horses, and usually he had from 15 to 20 head. Some were draft horses but he was more interested in carriage and saddle horses. For a while he was interested in racing on a small scale and entered a few horses in races at county fairs. He owned a gelding named "Saladin" of which he was particularly proud. As the children became older, he assigned them to the task of breaking some of the colts to harness and saddle. They had a hilarious time. Mrs. Swett was dreadfully afraid of horses. She complained for years of the danger to the children. Dr. Swett's optimism was justified, however, since they never experienced any severe injuries.

His old comrade Elmer Armstrong owned a horse farm at Hebbardsville in Athens County. Dr. Swett secured race horses usually from this source. If he saw a horse which he liked but which was not for sale he resorted to horse trading to secure the animal.

For a few years, Dr. Swett was postmaster, the postoffice being at his home. This was before the day of the rural carrier. It did not require much time, since the mail came through only once a week, by stage.

In 1894, he sold his farm and moved to Albany, a village in Athens County. Instead of establishing his office in the village, he bought a home with 10 acres of land about a mile north of the town. This was characteristic of his pattern of life. He wanted enough space in which to move around. A stone's throw from the house he built a small office. There he continued to practice on a limited basis until about 1900. Mrs. Swett died in 1895.

One of his sons, Davis, graduated from the Eclectic Medical College in Cincinnati in 1897. The son opened an office in Albany separate from his father and practiced there until his death in 1919.

After the Medical Practice Act became a law establishing licensure, along with others, Dr. Swett was granted a license in 1895 because of his experience and length of practice. He died in 1903.

Ohio Academy of G. P. . . .

Sixth Annual Scientific Assembly Scheduled at New Auditorium in Columbus, September 19-20; Outstanding Program Has Been Planned

THE SIXTH Annual Scientific Assembly of the Ohio Academy of General Practice has been scheduled for Wednesday and Thursday, September 19 and 20. All scientific sessions and exhibits will be in the new Franklin County Veterans Memorial Auditorium, across the bridge from the downtown Civic Center of Columbus and within walking distance of downtown hotels.

The Banquet, preceded by a social hour, will be in the Ball Room of the Deshler-Hilton Hotel.

The program has been announced as follows:

WEDNESDAY, SEPTEMBER 19

(All time, Eastern Standard)

- 8:00 A. M.—Registration and Visit Exhibits.
- 8:45 A. M.—Opening of Annual Scientific Assembly.
- 9:00 A. M.—H a z a r d s in Anesthesia—Jay Jacoby, M.D., Columbus.
- 9:30 A. M.—Principles of Electrolyte Therapy—Willard E. Hauser, M.D., Cleveland.
- 10:00 A. M.—Trends in Pediatric, Adult and Geriatric Nutrition—Thaddeus D. Labecki, M.D., Jackson, Miss.
- 10:30 A. M.—Visit Exhibits.
- 11:00 A. M.—Venous Thrombosis and Trypsin—Bert Seligman, M.D., Toledo.
- 11:30 A. M.—Evaluation of the Newer Types of Insulin—Thomas G. Skillman, M.D., Cincinnati.
- 12:00 M.—Informal Buffet Luncheon. Visit Exhibits.
- 1:30 P. M.—Herniated Lumbar Intervertebral Disk Problem—H. R. Oberhill, M.D., Chicago.
- 2:00 P. M.—Abnormal Uterine Bleeding—Frederick H. Falls, M.D., Chicago.
- 2:30 P. M.—Osteoarthritis—Joseph E. Levinson, M.D., Cincinnati.
- 3:00 P. M.—Visit Exhibits.
- 3:30 P. M.—Management of Congestive Heart Failure—Hugh Luckey, M.D., New York City.
- 4:00 P. M.—Cancer Detection in the Office of the Generalist—John S. DeTar, M.D., Milan, Michigan.
- 4:30 P. M.—Visit Exhibits.
- 6:30 P. M.—Social Hour and Banquet, Deshler-Hilton Hotel, Ball Room. Address: The Way To Win—Major Norman Imrie, Columbus, educator-editor-entertainer.

THURSDAY, SEPTEMBER 20

- 8:00 A. M.—Registration and Visit Exhibits.
- 9:00 A. M.—The Investigation and Treatment

of Recurring Urinary Infections—William J. Engel, M.D., Cleveland.

- 9:30 A. M.—Ultrasonics in Medicine—Herman J. Bearzy, M.D., Dayton.
- 10:30 A. M.—Visit Exhibits.
- 11:00 A. M.—Office Management of Leukorrheas—L. V. Dill, M.D., Washington, D. C.
- 11:30 A. M.—Treatment and Prevention of Lateral Rotation of Legs and Flatfeet in Small Children—J. H. Kite, M.D., Atlanta, Georgia.
- 12:00 M.—Informal Buffet Luncheon (South Exhibition Hall). Visit Exhibits.
- 1:30 P. M.—Psychotherapy in General Practice—Vernon P. Williams, M.D., Boston.
- 2:00 P. M.—Hypnosis for the General Practitioner—Seymour Hershman, M.D., Chicago.
- 3:00 P. M.—Visit Exhibits.
- 3:30 P. M.—Indications for the Ultimate Results of Splenectomy; A Twenty-Five Year Follow-Up Study—Charles A. Doan, M.D., Columbus.
- 4:00 P. M.—Premalignant Lesions of the Rectum and Colon—C. W. Mayo, M.D., Rochester, Minnesota.
- 4:30 P. M.—Adjournment.

Medical Society Leaders Invited To AMA's PR Institute

Concentrating on just one big public relations meeting this year, the American Medical Association announces plans for its 1956 PR Institute to be held August 29-30 at Chicago's Drake Hotel. This two-day session will combine the socio-economic discussions formerly reserved for the PR Conference with the idea exchanges usually on the Institute program.

Tentatively scheduled are discussions on: Science Fairs, legislation, membership indoctrination, tested public relations activities, and the outlook for next year. In addition, a half day will be devoted to a radio-television workshop on local programming.

Especially invited are the men and women who work with medical society public relations programs—society officers, PR committee chairmen, society lay personnel, auxiliary PR chairmen, and medical school PR personnel. Registrants will be the guests of the Association at luncheon sessions. Room reservations should be made directly with the Drake Hotel.

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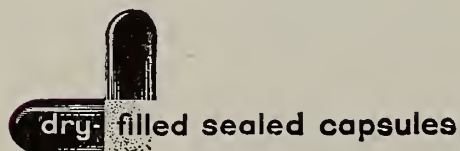
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ACHPRODONTEN



Dr. Mayfield of Cincinnati Is Named A Member of the OSMA Council From the First District

New member of The Council of the Ohio State Medical Association, representing the First Councilor District, is Dr. Frank H. Mayfield, Cincinnati. He will serve in place of Dr. Charles T. Atkinson, Middletown, who resigned because of illness.

Dr. Mayfield was elected by The Council by a mail ballot under Section 7, Chapter 7, of the By-Laws, authorizing The Council to fill a



DR. MAYFIELD

vacancy by appointment. He will serve until the 1957 Annual Meeting at which time The House of Delegates will act to fill the office for the remaining year of Dr. Atkinson's two-year term.

At the time of his election Dr. Mayfield was serving as chairman of the Committee on Public Relations and Economics of the Ohio State Medical Association and chairman of the Subcommittee on Legislation of that committee. He will continue to serve in those offices until his successors are appointed by President Meiling.

Dr. Mayfield is a former president of the Academy of Medicine of Cincinnati and has held many other important offices in that society. A Fellow of the American College of Surgeons he is also on the Board of Governors of that organization and chairman of its Subcommittee on Head Trauma. He is also a Fellow and past-president of the American Society of Neurological Surgeons. Other organizations with which he is associated are the Harvey Cushing Neurosurgical Society, and the American Association for the Surgery of Trauma.

A diplomate of the American Board of Neurological Surgery, he is assistant professor of clinical surgery of the University of Cincinnati College of Medicine and consulting or attending neurosurgeon at many of the Cincinnati and neighboring hospitals. He is also a member of the Board of Directors of the University of Cincinnati.

Dr. Mayfield holds the rank of Lieutenant Colonel in the Medical Corps, AUS, and is area consultant in neurosurgery for the Veterans Administration. He is vice-chairman of the Section on Nervous and Mental Diseases of the American Medical Association.

A list of 29 courses in postgraduate medicine offered by the Post-Graduate Medical School, New York University, is available by writing to the dean at 550 First Ave., New York 16.

New Regulation Allows Income Tax Deductions for Postgraduate "Refresher" Type Courses

The U. S. Internal Revenue Service has issued a regulation which is important to physicians. Efforts over a long period of time by the A.M.A. Law Department to get the Internal Revenue Service to issue a regulation permitting physicians to deduct their expenditures in taking postgraduate "refresher" courses have paid off.

The regulation, effective on August 9, provides that expenditures for education are deductible if they are for a "refresher" or similar type of course taken to maintain the skills directly and immediately required by the physician in his employment or business. An educational course to be covered should be designed for established medical practitioners to help them keep abreast of current developments in the profession; it should be of short duration; it should not be taken on a continuing basis, and should not carry academic credit. Education designed to prepare the practitioner to enter a specialty will not be acceptable.

When a physician travels away from home primarily to obtain "refresher" education, his expenditures for travel, meals, and lodging while away from home are deductible. However, expenses for personal activities such as sight-seeing, social visiting or entertaining, or other recreation will not be allowed.

New Members of O. S. M. A.

The following are the names of the new members of The Ohio State Medical Association since June 1, 1956. The list shows the county in which they are affiliated, city in which they are practicing, or temporary address in cases where physicians are taking postgraduate work.

BUTLER COUNTY

James L. Sawyer,
Middletown

CUYAHOGA COUNTY

Alfred G. Gerchione,
Cleveland

William D. Grant,
Cleveland

Richard J. Honard,
Cleveland

David Mendelsohn,
Cleveland

George Mineff, Cleveland

Stanley M. Pariser,
Cleveland

Martin L. Smith,
Cleveland

Borivoj Vyroubal,
Cleveland

DEFIANCE COUTNY

Thad J. Earl, Defiance

Paul B. Kerr, Hicksville

ERIE COUNTY

Douglas V. Auld,
Sandusky

FRANKLIN COUNTY

Joseph A. Bonta,
Columbus

William M. Lordi,
Columbus

Sidney W. Nelson,
Columbus

Howard D. Sirak,
Columbus

Orliss Wildermuth,
Columbus

James E. Williams,
Columbus

GALLIA COUNTY

Stefan L. Vergesslich,
Gallipolis

HAMILTON COUNTY

Paul G. Geiss, Cincinnati

Richard L. Witt,
Cincinnati

LORAIN COUNTY

Paul L. Maitheny, Lorain

LUCAS COUNTY

Joseph M. Garland, Toledo

Barton T. Smith, Toledo

MEDINA COUNTY

Hermann M. Velbinger,
Lodi

AMA Annual Session . . .

Resumé of Official Actions of House of Delegates; More than 500 Ohio Physicians Attended; Buckeye Delegation Takes Active Role.

MANY OF THE 537 Ohio physicians who attended the 105th Annual Meeting of the American Medical Association June 11-15, in Chicago, were active in the business and scientific sessions.

Serving on reference committees of the AMA House of Delegates were: Dr. C. C. Sherburne, Columbus, Committee on Amendments to the Constitution and Bylaws; Dr. Herbert B. Wright, Medical Military Affairs; and Dr. Carl A. Lincke, Carrollton, Rules and Order of Business.

Other Ohio delegates were: Drs. Paul A. Davis, Akron; Richard L. Meiling, Columbus; Carl S. Mundy, Toledo; L. Howard Schriver, Cincinnati; and George A. Woodhouse, Pleasant Hill. Dr. Charles L. Leedham of Cleveland was the delegate from the Section on Military Medicine.

WINS SILVER MEDAL

The Hektoen Silver Medal for original investigation was awarded to Dr. Edwin H. Ellison of Columbus for his exhibit on The Ulcerogenic Tumor of the Pancreas. Dr. Ellison's exhibit previously won the top award for original investigation at the Ohio State Medical Association Scientific Exhibit this year in Cleveland.

HOSPITAL ACCREDITATION

Among resolutions presented at the AMA House of Delegates session was one from Ohio on hospital accreditation, the essence of which was contained in the report of a special committee of the House. The latter was adopted and appears on page 870 of this issue of *The Ohio State Medical Journal*.

Offered for the second time by the Ohio delegates was a resolution which originated in an action of the OSMA House of Delegates two sessions ago, regarding restrictions in the use of radium and radioactive isotopes.

REFERRED TO SPECIAL COMMITTEE

This resolution called for the repeal of a stand taken in June 1951 by the AMA House of Delegates, recommending that the use of these materials be under the supervision of one certified in Radiology or Therapeutic Radiology.

It was introduced by Dr. Lincke, and was supported in the Reference Committee on Miscellaneous Business by Drs. William G. Myers and Florence Lenahan of Columbus; and on the floor of the House by Dr. Meiling.

As the result of a compromise, the matter was referred to a special committee to be appointed by the Speaker of the House. It is to

conduct an investigation and make recommendations to the House of Delegates at the November session in Seattle.

A resolution setting up an AMA rotating scholarship fund for medical students, introduced by Dr. Edward J. McCormick, Toledo, past-president of the AMA, was referred to the Board of Trustees.

MEDICAL ETHICS

The House of Delegates voted in favor of a reference committee report approving revision of the Principles of Medical Ethics to a ten-paragraph statement of fundamentals accompanied by a brief preamble.

Final action on this matter will be taken at the Seattle session. The full story and the text of the revised principles appear on page 864 of this issue of *The Ohio State Medical Journal*.

FOREIGN GRADUATES

Approved in principle was a proposed program for the evaluation of graduates of foreign medical schools seeking hospital positions in the United States.

It calls for the establishment of a central administrative organization to evaluate the medical credentials of foreign trained physicians desiring to serve as interns or residents.

Basic requirements would include satisfactory evidence of at least 18 years of total formal education, including a minimum of 32 months in medicine, exclusive of any time which in this country would be considered as premedical study or internship.

Applicants with satisfactory credentials then would take a screening examination to determine their medical knowledge and their facility with the English language. Those successful would be certified to hospitals and other interested organizations.

The program was developed by the Cooperating Committee on Graduates of Foreign Medical Schools, representing the AMA Council on Medical Education and Hospitals, American Hospital Association, Association of American Medical Colleges, and the Federation of State Medical Boards.

POLICY ON MEDICAL TEACHERS

Another action by the House involved the problem of private practice by medical school faculty members, which has been under study by the Committee on Medical and Related Facilities of the Council on Medical Service.

Adopted in this connection was a Council

report which stated "that it shall be the policy of the American Medical Association that funds received from the private practice of medicine by salaried members of the clinical faculty of the medical school or hospital should not accrue to the general budget of the institution and that the initial disposition of fees for medical service from paying patients should be under the direct control of the doctor or doctors rendering the service."

The report also said "It is not in the public or professional interest for a third party to derive a profit from payment received from medical services, nor is it in the public or professional interest for a third party to intervene in the physician-patient relationship."

OTHER ACTIONS TAKEN

Reaffirmed by the House was a previous policy approving in principle one-time Federal matching grants to medical schools for construction purposes.

Other actions called for the development of guiding principles by drug manufacturers and the medical profession with regard to premature release of information on new products; approved a Board of Trustees statement regarding the danger of the disability proposal in the Social Security Bill, HR 7225; and authorized the Committee on Federal Medical Services to make a continuing study of all aspects of Veterans Administration medical activities under the basic policy established in 1953.

ELECTION OF OFFICERS

Dr. David B. Allman of Atlantic City, New Jersey, was named president-elect for the coming year. He will become president of the AMA at the June, 1957 meeting in New York City, succeeding Dr. Dwight H. Murray of Napa, California, who took over from Dr. Elmer Hess of Erie, Pennsylvania at this year's session.

Dr. Franklin S. Crockett, Lafayette, Indiana, who has been Chairman of the Council on Rural Health of the AMA since its inception was elected Vice-President.

Dr. Julian Price of Florence, S. C., was re-elected to the Board of Trustees, and Dr. Hugh Hussey of Washington, D. C., was named to succeed Dr. Allman on the Board.

Connecticut Releases 17-Year Cancer Registry Report

The Connecticut State Department of Health has made public a comprehensive report, "Cancer in Connecticut—1935-1951," which presents data on 75,494 cases during the 17-year period as recorded in the Connecticut Cancer Record Register. The report was issued by Dr. Matthew H. Griswold, chief of the Division of Cancer and Other Chronic Diseases.

Congress Pours Financial Aid into Various Research Programs Beyond Fondest Hopes

If medical research doesn't move ahead in the current fiscal year (ending June 30, 1957), it won't be the fault of Congress. The seven research organizations that make up the National Institutes of Health have far more money than they have ever had, and probably much more than their directors even dared hope for last winter at the start of hearings on their budgets. Every one of the research institutes received a substantial increase over last year, and the funds of five of them were almost doubled.

The Institutes have a total of \$170.4 million to spend before next July 1. This is about 80 per cent more than they had last year. In discussing the appropriations bill on the Senate floor, Senator Lister Hill (D., Ala.) said the bulk of the money will go for grants to non-federal institutions—hospitals, medical schools, clinics and state and local organizations engaged in research.

A breakdown by disease categories shows the following picture:

For cancer research, \$48.4 million, in contrast to \$24.8 million for the previous year. This year's total is \$16 million more than the administration asked when budget requests were sent to Congress in January.

For mental health work, \$35.1 million, in contrast to last year's \$18 million. This is \$13.4 million more than had been requested originally.

For heart disease research, \$33.3 million, compared with \$18.7 million last year and \$22.1 million originally requested.

For work on arthritis and metabolic diseases, \$15.8 million, or \$5.1 million more than last year and \$2.5 million more than Congress was asked for.

For research in neurology and blindness, \$18.6 million, compared with \$9.8 million last year and \$12.1 million originally requested.

For work on allergies and infectious diseases, \$13.2 million, compared with \$7.5 million last year and \$9.7 requested.

For dental research, \$6 million. While this is small compared with money voted for other U. S. research institutes, it is almost triple the \$2.1 million spent last year.

Other federal health programs, mainly concerned with disease control and hospital construction, also fared well with the Congress. The Hill-Burton program, for construction grants to hospitals, has \$125 million for the current year, or \$14 million more than last year. For vocational rehabilitation grants, the figure is \$41.5 million, a \$2.7 million increase; for general public health assistance to states, it is \$18.16 million, a \$600,000 increase; for Indian health work, it is \$38 million, a \$3.3 million increase.



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New Aid for Aged Medical Program . . .

“Pool Fund” Created Under Provisions of New Law; \$200 Ceiling Per Case Eliminated; Revised Medical and Surgical Fee Schedule Is Established

A REVISED health care program for recipients of Aid for the Aged is now in operation in Ohio under the provisions of a law (Sub. H. B. 592) enacted at the regular session of the Ohio General Assembly in 1955 and effective July 1, 1956.

The revised program allows the Division of Aid for the Aged of the Ohio Department of Welfare to finance medical, surgical, dental, optometrical and hospital services; costs of drugs and supplies; and nursing and convalescent care “in cases of extraordinary need” without a ceiling on the amount which may be spent in any one case. Heretofore, there had been a \$200 ceiling a year in each case.

WILL HAVE “POOL FUND”

Under the terms of the amended law, the Division has established a “pool fund” from which those rendering health services will be paid. The fund will consist of money from the regular appropriations of the Division, amounting to \$6.00 per recipient per month, including Federal funds available for health care programs of this kind. It is estimated that the fund will total between 7 and 8 million dollars per year.

It is the hope of officials that most of the health needs of recipients of Aid for the Aged can be met under this revised program, making supplementation by Poor Relief Authorities unnecessary. However, no change has been made in the State Poor Relief Act which places the responsibility for supplying medical care and other health services for persons in need, on relief authorities, even though such persons may be receiving aid through other programs of public assistance, including Aid for the Aged.

MEDICAL DIRECTOR NAMED

Effective August 1, administrative details of the revised health care program will be handled by Dr. C. R. Wilcox, recently appointed Medical Director. A graduate of Johns Hopkins University School of Medicine, Dr. Wilcox recently retired after 30 years active duty in the U. S. Navy Medical Corps. Dr. William F. Ashe, chairman, Department of Preventive Medicine, Ohio State University College of Medicine, who has been serving as medical consultant to the Division of Aid for the Aged will continue to serve in that capacity.

REVISED FEE SCHEDULE ADOPTED

The Ohio Department of Public Welfare has adopted a medical and surgical fee schedule for

use in all programs of the department where payment is made directly by the state to the physicians rendering the services. These programs are: Health Care Program of the Division of Aid for the Aged; Crippled Children's Services; and Vocational Rehabilitation Services for the Blind.

Some of the specialized services rendered under the Crippled Children's Program and Vocational Rehabilitation Services for the Blind are not listed in the revised general fee schedule but are covered in supplemental fee schedules maintained by those two services.

LAW AUTHORIZING PROGRAM

Here is a part of Sec. 5105.07 of the Revised Code, as amended by the last General Assembly, which provides the authority for the new health care program of the Division of Aid for the Aged:

“In cases of extraordinary need and in so far as not in conflict with the basis of need established under federal law, an additional payment may be made to the recipient or, at the option of the division, to other persons or agencies in accordance with schedules of payment for medical, surgical, dental, optometrical, hospital, or necessary nursing and convalescent care, and medical supplies and drugs, required because of illness or disability of a recipient of aid under this section and within the rules and regulations of the division. Such schedules of payment shall be adopted for each county by the division. The division may pay for the cost of customary services rendered to recipients of aid by outpatient departments of nonprofit hospitals without regard to any of the limitations provided in this section on the amount of aid payable. Payments for such services shall be computed on the basis of the actual cost for each visit or on the basis of the actual average patient visit cost to the hospital, and such payments may be made periodically in one sum for all the services rendered to recipients during a period to be determined by the division. The division, through its county subdivisions, may contract to provide medical, surgical, and hospital care for recipients of aid under this section. With the approval of the controlling board, the division may establish a medical payment fund to be used solely for payment for medical, surgical, dental, optometrical, hospital, or necessary nursing and convalescent care, and medical supplies and drugs, required because of illness or disability of a recipient. Deposits into such fund shall be made by the division from

moneys appropriated to the division for subsidies, including the moneys made available to the state by the federal government for this purpose. Such deposits shall be based upon a per capita amount per recipient, not to exceed six dollars per month, said amounts to be determined from time to time by the division with approval of the controlling board. The division is authorized to establish such conditions as will comply with federal requirements for a pool fund to which partial federal reimbursement can be earned. The division shall make rules and regulations governing payments from such fund."

EFFECTIVE JULY 1

The new general fee schedule became effective July 1, 1956. Bills submitted for services rendered on or after July 1 to persons aided by the three programs previously mentioned will be honored in accordance with the new fee schedule.

OSMA COMMITTEE HELPED

When the Ohio Department of Welfare started to set up the new health care program for the

Division of Aid for the Aged, it asked the Ohio State Medical Association to name a committee to advise with it. On authorization of The Council, President Meiling appointed an ad hoc committee of five. It was composed of Drs. Edmond K. Yantes, Wilmington, chairman; James R. Jarvis, Van Wert; William D. Monger, Lancaster; Roger E. Heering, Columbus; and Jerome P. Hochwalt, Dayton. At several long meetings, the committee drafted suggestions for the revised fee schedule and recommendations for administrative rules and regulations to be considered later by the new medical director, Dr. Wilcox. Not all—but most—of the recommendations regarding the new fee schedule submitted by the committee to the department were adopted.

Following is the revised Medical and Surgical Fee Schedule of the Ohio Department of Welfare. It became effective July 1, 1956 and applies to services rendered in connection with the health care programs of the Division of Aid for the Aged; Services for Crippled Children; and Vocational Rehabilitation Services for the Blind.

MEDICAL AND SURGICAL FEE SCHEDULE
OF
OHIO DEPARTMENT OF WELFARE

GENERAL

* Asterisk denotes that fee allowed is in addition to the regular treatment fee.

Fee for routine office and home calls includes ordinary medication and dressings.

Treatment at office (day)	\$ 3.00
Treatment at home (day)	4.00
Treatment at hospital (day)	3.00
Treatment (emergency) office, home or hospital between 10 P. M. and 7 A. M.	7.00
History and complete physical examination when deemed necessary for diagnostic purposes or vocational rehabilitation	10.00
*Suturing lacerations (minor)	3.00
(In cases requiring unusual treatment, payment of an additional amount may be requested. Detailed explanation should accompany such request.)	
*Injections (including cost of medication):	
Antitetanic serum (prophylactic)	\$ 2.00
Combined gas bacillus and tetanus antitoxin (prophylactic)	4.00
Intravenous	1.50
Intramuscular	1.00
Assistant to surgeon, major operation, 20% of the fee allowed surgeon but not less than	10.00
(Payable only in hospitals where there is no accredited intern or resident program.)	

Consultation and report at request of attending physician	\$ 10.00
*Mileage, outside corporation limits and for calls to place of residence only, per mile one way	\$.50

EXAMINATIONS

Electrocardiogram with interpretation	\$ 10.00
Electro-Encephalogram	15.00
Pneumo-Encephalography, exclusive of X-ray	25.00
Myelography (exclusive of X-ray)	15.00
Special ear examination, including audiometric test, with chart	10.00
Special ear examination to include either caloric or Barany test, or both, with report	10.00
Examination of eyes with refraction	10.00
Allergic investigation, including complete examination, allergy study and report (adults)	40.00

ENDOSCOPY

Bronchoscopy (for aspiration or subsequent)	\$ 25.00
Bronchoscopy (with biopsy or removal of foreign body)	50.00
Cystoscopy, genito urinary examination	25.00
Cystoscopy, with ureteral catheterization	35.00
Esophagoscopy (with or without biopsy)	25.00
Esophagoscopy (with removal of foreign body)	50.00
Gastrosocopy	25.00

(Continued on Next Page)

Sigmoidoscopy (with or without biopsy) ..	10.00
Thoracoscopy	50.00

CLINICAL LABORATORY
EXAMINATIONS

Bacteriological Examinations

(The amounts listed under "Clinical Laboratory Examinations" are exclusive of the regular treatment fees.)

Microscopic examination for fungi	\$ 1.00
Pus or exudate (smear)	1.00
Throat smear	1.00
Culture examination, including classifica- tion of microorganism	5.00
Sensitivity determination of micro- organism	5.00

Blood

Agglutination test for typhoid, para- typhoid, dysentery, or undulant fever ..	3.00
Bleeding time	1.00
Blood calcium	3.00
Blood chlorides	3.00
Blood platelet count	2.00
Carbon dioxide combining power of blood plasma (Van Slyke)	3.00
Cholesterol	3.00
Coagulation time	1.00
Creatinin	3.00
Dextrose	3.00
Erythrocyte count (total)	1.00
Fragility test for erythrocytes	3.00
Glucose tolerance test	8.00
Hemoglobin estimation	1.00
Hydrogen ion concentration	3.00
Leukocyte count (differential)	1.00
Leukocyte count (total)	1.00
Complete blood count, including hemato- crit count, total erythrocyte count, hemoglobin estimation, differential leukocyte count and total leukocyte count	5.00
Without hematocrit count	3.00
Non-protein nitrogen	3.00
Phosphatase (alkaline and acid)	3.00
Phosphorous (blood)	3.00
Precipitation test for syphilis	1.00
Prothrombin time	3.00
Reticulocyte count	2.00
Sedimentation rate	1.00
Thymol turbidity test	2.00
Urea nitrogen	3.00
Uric acid	3.00
Van den Bergh blood test for icterus	2.00

Feces

Fat in feces	\$ 1.00
Occult blood	1.00

Pathological Examinations

Tissue examination	\$ 5.00
Cytological test	5.00

Spinal Fluid

Examination of spinal fluid for causative organism (smear)	\$ 1.00
Cell count	1.00
Colloidal gold reaction	3.00
Globulin test	1.00
Precipitation test for syphilis	2.00
Tubercle bacillus (concentration method)	3.00

Stomach Contents

Examination of duodenal content for pan- creatic ferments	\$ 3.00
Examination of gastric content for acidity, by histamine	3.00
Examination of gastric content for pepsin	3.00
Routine, chemical (including test meal and withdrawal of stomach content)	5.00

Urine

Urinalysis (chemical and microscopic) ...	\$ 1.00
Chlorides	3.00
Creatinin	3.00
Mosenthal test	3.00
Total nitrogen	3.00
Renal function test, (including phenol- sulfonphthalein)	3.00
Urobilin	1.00

MISCELLANEOUS EXAMINATIONS

Determination of basal metabolic rate ...	\$ 5.00
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SURGICAL PROCEDURES

The flat fee listed herein includes after-care for a period of sixty days unless otherwise specified.

* Asterisk denotes that the fee allowed is in addition to the regular treatment fee and that after-care is not included.

If two or more surgical procedures are performed on the same patient by the same physician concurrently or immediately successively, the fee for the two or more procedures will be the greater fee plus one-half each smaller fee. The fee for multiple operation will never exceed twice the greater or greatest fee.

If two surgical procedures are performed by two different physicians on the same patient concurrently or immediately successively, the fee for each surgeon will be seventy-five per cent of the fee listed for each operative procedure.

Abdominal fixation for prolapse of rectum	\$150.00
Adenectomy, cervical, inguinal, etc. (minor)	20.00
Adenectomy, cervical, inguinal, etc. (radical)	150.00
Anal fissure, operation for	30.00
Anastomosis, intestinal	150.00
Anastomosis, uretero-intestinal	150.00
Ankle joint, excision of	100.00

Apicolysis	100.00	Lobectomy	150.00
Appendectomy	100.00	Lumbar Puncture, including local anes- thetic and obtaining fluid	10.00
*Biopsy (exclusive of after-care)	5.00	Meckel's diverticulum, excision of	100.00
Bone graft (long bones)	150.00	Nephrectomy or Nephrotomy	150.00
Bone plate, removal of	50.00	Nephropexy	125.00
Bowel, resection of large	200.00	Nerve suture (immediate) major nerve ...	75.00
Breast, resection of (simple)	100.00	Nerve suture (late) major nerve, including neurolysis if performed	150.00
Breast, resection of (radical)	150.00	Neurolysis (late) major nerve, including transplantation if performed	150.00
Carcinoma of lower lip, excision of	50.00	*Supra-orbital nerve, injection of	5.00
Carcinoma of rectum, excision of	200.00	Neuroma, resection of	75.00
Carcinoma of tongue, excision of	50.00	Orchidectomy	50.00
Cartilage of condyle of femur, removal of	100.00	Osteomyelitis, operation for small bones ...	50.00
Semilunar cartilage, removal from joint ...	100.00	Large bones, (tibia, fibula, femur, hu- merus, radius, ulna, skull, spine, pelvis)	100.00
Cervix, amputation of (trachelorrhaphy)	75.00	Papilloma of bladder, operation for	75.00
Cervix, conization	25.00	Paracentesis of abdomen	15.00
Cholecystectomy (Removal of gall bladder)	150.00	Paracentesis of pericardium	25.00
Cholecystectomy (Incision into the gall bladder)	100.00	Paracentesis of thorax	10.00
Choledochotomy (Incision into the common bile duct)	150.00	Perineum, repair of	75.00
Chordotomy	150.00	Phrenic nerve operation	50.00
Circumcision	25.00	Pneumolysis, extrapleural or intra- pleural	100.00
Claw foot, operation for	75.00	Pneumectomy	200.00
Coccyx, excision of	50.00	Pneumonotomy, cautery	100.00
Colostomy	100.00	Prostatectomy, perineal	150.00
Colporrhaphy (repair of rupture of vagina)	75.00	Prostatectomy, suprapubic (one or two stages)	150.00
Cystotomy, suprapubic	75.00	Prostatic resection, transurethral	150.00
Dupuytren's contraction, operation for ...	125.00	Pyclotomy, with removal of calculus	150.00
Elbow joint, excision of	150.00	Salpingectomy, removal of Fallopian tube	100.00
Epididymectomy	75.00	Saphenous vein ligation	75.00
Fecal fistula, abdominal, operation for ...	150.00	Saphenous vein ligation with stripping or segmental ligation	100.00
Fistula, rectovaginal, operation for	150.00	Scalenotomy	50.00
Fistula, urethral, operation for	100.00	Sequestrum, removal of (deep) (Specify what is done)	\$50.00 - 150.00
Fistula, vesicovaginal, operation for ...	150.00	Skull, decompression of	100.00
Fistula-in-ano, operation for	50.00	Fixation of spine, operation for	150.00
Fulguration of tumor of bladder, trachea, or esophagus (minor)	50.00	Stricture of rectum, operation for	50.00
*Fulguration of tumor, superficial	5.00	Sympathectomy, cervical	175.00
Ganglion, excision of	30.00	Sympathectomy, periarterial	100.00
Gasserian ganglion, excision of	150.00	Tendon (toe) repair of	30.00
Gastrectomy	200.00	Each additional tendon	15.00
Gastro-enterostomy	150.00	Tendon (finger) repair of:	
Hallux valgus, operation for	60.00	Flexor tendon	75.00
Hammer toe, operation for	25.00	Extensor tendon	50.00
Hemorrhoidectomy	50.00	Each additional tendon 50% of above fees . . . Maximum	150.00
Herniotomy, diaphragmatic	150.00	Tenotomy	25.00
Herniotomy, ventral, inguinal, or femoral (adult)	100.00	Thoracotomy	100.00
Herniotomy, ventral, inguinal or femoral (child)	50.00	Thoracoplasty, each stage	100.00
Herniotomy, ventral, inguinal, or femoral (bilateral)	150.00	Thyroidectomy	150.00
*Hydrocele, aspiration of	5.00	Toe nail, ingrown, radical incision of	25.00
Hydrocele, operation for	50.00	Torticollis, operation for	75.00
Hysterectomy, abdominal or vaginal (in- cluding removal of adnexa and appendix, if indicated)	150.00	Tumor, abdominal, removal of	125.00
Intestinal obstruction, operation for	150.00	Tumor of brain, operation for (range)	\$150.00 - 200.00
Knee joint, excision of	150.00		
Laminectomy	150.00		
Laparotomy, exploratory	100.00		

(Continued on Next Page)

Tumor, gastro-intestinal tract, resection of, including intestinal anastomosis	150.00
Tumor or cyst, deep, removal of	25.00
*Tumor or cyst, superficial, removal of ...	10.00
Ulcer, gastric or duodenal, operation for ..	150.00
Ureteral stone, open removal of	125.00
Urethral stricture, each dilatation of	5.00
Urethrotomy, external	75.00
Urethrotomy, internal	50.00
Prolapsus uteri, operation for, including perineal repair	150.00
Uterus, dilatation and curettage of	50.00
Varicocele, operation for	50.00
Varicose veins, injection treatment, each injection	5.00
Whitehead's operation	75.00
Wrist joint, excision of	100.00

AMPUTATIONS

The flat fee includes amputation and sixty days' after-care unless otherwise specified. (Adults only; For Children, see Crippled Children Services Fee Schedule)

In cases of more than one amputation, the fee shall be the major one, and an additional fifty per cent of each of the others.

Thigh at hip joint (disarticulation)	\$150.00
Thigh at knee joint or above	125.00
Leg below knee to ankle joint, inclusive ...	100.00
Through foot	75.00
Arm at shoulder joint	150.00
Hand at wrist joint and forearm or arm ...	100.00
Finger	30.00
Toe	30.00

ANESTHESIA

No additional fee is paid to the anesthetist for the anesthetic material or for transfusions given during the anesthetic.

Inhalation, block, intravenous, spinal or rectal:	
First thirty minutes or fraction thereof \$	15.00
Each additional thirty minutes or fraction thereof	5.00
Local anesthesia used in reduction of fracture or dislocation	5.00

No additional fee is approved for local anesthesia used in connection with treatments at office, home or hospital.

DISLOCATIONS

The flat fee includes reduction and sixty days' after-care unless otherwise indicated.

In a case of more than one dislocation, the fee shall be the major one, and an additional fifty per cent of the fee designated for each of the others herein classified.

In cases involving fractures, also, the fee

shall be the major one, and an additional fifty per cent for each of the others.

Casts applied during the period covered by the flat fee are considered as part of the treatment and no extra fees for application are approved.

Shoulder	\$ 35.00
Clavicle	50.00
Elbow	50.00
Hip	75.00
Knee	75.00
Patella	10.00
Ankle	40.00
Finger	10.00
Toe	10.00
Lower jaw	10.00
Carpal bones	50.00
Vertebra	150.00

EAR, NOSE AND THROAT SURGICAL PROCEDURES

The flat fee includes after-care for a period of three weeks, unless otherwise indicated.

Mastoid, acute, operation for	\$100.00
Mastoid, radical, operation for	150.00
Ossiculectomy	100.00
Paracentesis tympani	10.00
Polypus, removal of	25.00
Lateral sinus, drainage of	150.00
Adenoidectomy (adult)	20.00
Antrum, intranasal, drainage of	20.00
Antrum, radical, operation for	100.00
Laryngectomy (excision of larynx)	150.00
Larynx cauterization of	25.00
Tumor of larynx, removal of	50.00
Nasal polypus, removal of	25.00
Nasal septum, submucous resection	75.00
Pharyngeal abscess, operation of	25.00
Accessory nasal sinuses, irrigation of	10.00
Ethmoid sinus, radical, operations for	75.00
Frontal sinus, intranasal, drainage of	50.00
Frontal sinus, radical, operation for	100.00
Sphenoid sinus, drainage of	50.00
Tonsillar abscess, operation for	15.00
Tonsillectomy (adult)	40.00
Tonsillectomy and adenoidectomy (adult) ..	50.00
Tracheotomy	50.00
Turbinate bone, galvano-cauterization of ..	20.00
Turbinectomy	25.00

FRACTURES

The flat fee includes reduction and casts and sixty days' after-care unless otherwise indicated.

In a case where more than one bone is fractured, the fee shall be the major one and an additional fifty per cent of the fee designated for each of the others.

In cases involving dislocation also, the fee shall be the major one, and an additional fifty per cent for each of the others.

Casts applied or reapplied during the period covered by after-care are considered part of

the treatment and no additional fees for application of cases will be approved.

Compound fractures—An additional fee of fifty per cent is approved in compound fractures.

Open operations—An additional fee of fifty per cent, except where otherwise specified in the fee schedule, is approved when it is necessary to perform an open operation for reduction and fixation. This includes all materials used in suturing, plating and nailing and is not in addition to the amount approved for compound fractures.

Astragalus, non-operative	\$ 50.00
Astragalus, operative	100.00
Carpal bones, except scaphoid	25.00
Carpal scaphoid	50.00
Clavicle	50.00
Coccyx—(Without operation and exclusive of after-care)	10.00
Coccyx—Surgical removal, (including after-care)	50.00
Colles' fracture (including fractured tip of styloid and dislocation of head of ulna) ..	50.00
Femur	125.00
Fibula	35.00
Humerus	100.00
Mandible (non-operative and not requiring interdental wiring)	25.00
Mandible (single fracture requiring interdental wiring)	75.00
Mandible, (multiple fractures requiring interdental wiring)	100.00
Mandible (operative)	125.00
Maxilla (non-operative and not requiring interdental wiring)	25.00
Maxilla (single fracture requiring interdental wiring)	75.00
Maxilla (multiple fractures requiring interdental wiring)	100.00
Maxilla (operative)	125.00
Mandible and maxilla	150.00
Metacarpal bone	25.00
Metatarsal bone	25.00
Nasal bones, requiring manual adjustment only	10.00
Nasal bones, requiring intranasal manipulation and packing	25.00
Oscalcis, non-operative	50.00
Oscalcis, operative	100.00
Patella non-operative	50.00
Patella, suturing or plating or excision	100.00
Phalanx	20.00
Pelvis	75.00
Radius or ulna	50.00
a. Head or neck of Radius	60.00
Radius and ulna	100.00
Rib or ribs, (uncomplicated)	20.00
Sacrum	75.00
Scapula	50.00
Skull, operative	100.00
Sternum	75.00

Tarsal bone, other than oscalcis or astragalus	25.00
Tibia	75.00
Tibia and fibula	100.00
Vertebrae, one or more	150.00

INCISION AND DRAINAGE OF ABSCESS

The flat fee includes fifteen days' after-care unless otherwise indicated.

Brain abscess	\$150.00
Carbuncle, excision of	25.00
Cellulitis, incision and drainage	25.00
Deep abscess (including ischiorectal) plus after-care	25.00
Empyema, incision and drainage, including rib resection	100.00
Liver abscess	150.00
Oral abscess (not to include dental or peridental)	15.00
Prostatic abscess, incision and drainage	50.00
Superficial abscess. Fee does not include usual 15 days' after-care. Additional charge may be allowed for after-care....	5.00
Subphrenic abscess	150.00

OPHTHALMOLOGICAL PROCEDURES

The flat fee includes sixty days after-care unless otherwise indicated.

Cataract, needling operation for	\$ 35.00
Cataract, operation for	150.00
Chalazion, operation for	10.00
Corneal ulcer, cauterization of (chemical) ..	5.00
Corneal ulcer, cauterization of (thermal) ..	10.00
Extensive peripheral corneal ulcer, cauterization of	25.00
Ectropion, operation for	50.00
Entropion, operation for	50.00
Enucleation of eye:	
Simple operation	75.00
Implantation operation	100.00
Removal of foreign body:	
Simple. Regular treatment fee.	
Embedded, difficult, complicated or multiple	5.00 to 15.00
Grattage of lids for trachoma	10.00
Hordeolum, operation for	5.00
Iridectomy	75.00
Lacrymal duct, dilation of	10.00
Lacrymal sac, excision of	50.00
Pterygium, operation for	25.00
Ptosis, skin and tarsal resection, operation for	100.00
Strabismus, operation for (prior authorization required)	75.00 - 125.00
Trephine	100.00

PHYSIOTHERAPY

Fee for physiotherapy will be the regular treatment fee.

Fees will not be approved for more than ten treatments unless authorized. The nature of the

(Continued on Next Page)

disability must clearly indicate the necessity for such treatment. Additional fees for physiotherapy in cases covered by a flat fee are not approved without specific authorization. The term physiotherapy includes such treatment as manipulation, massage and all types of thermal, electrical and hydrotherapy. (Also see Crippled Children Services Fee Schedule.)

PLASTER CASTS

Fees for application of plaster casts in adult cases not covered by flat fee. Fees listed include the cost of materials and are in addition to the regular treatment fee. (Also see Crippled Children Services Fee Schedule.)

*Head, neck and torso	\$ 40.00
*Body cast (axillae to trochanters)	40.00
*Shoulder spica, including arm, forearm, hand and body to trochanters	45.00
*Arm, elbow and forearm	10.00
*Hand, wrist and forearm	10.00
*Hip spica, single or double	45.00
*Thigh, knee and leg	20.00
*Leg, ankle and foot	10.00
*Unna paste boot or similar modification	5.00

PSYCHIATRIC PROCEDURES

Electro-Encephalography	\$ 15.00
Psychotherapy, first hour	15.00
(Subsequent Interview)	5.00
Shock therapy (metrazol, insulin, electro, etc.)	25.00
(Psychotherapy and Shock therapy must have prior authorization and will normally be arranged for in a state mental hygiene clinic.)	

X-RAY (DIAGNOSTIC)

First examination of one part of body	10.00
First examination of additional parts of body	10.00
Except for examination of toes, metatarsals and parts distal to the elbow for which the fee is	5.00
Subsequent examinations of same part of body	7.50
Except for examination of toes, metatarsals and parts distal to the elbow for which the fee is	5.00
For examinations requiring special views e. g., stereoscopic, obliques, spot and standing views, the fee for each study in addition to the fees listed above is	5.00
The fee for first examination is paid for a subsequent examination of the same part if it is made sixty days or more after the previous examination.	
Colon examination by barium enema	20.00
Dental examination:	
Single film	2.00
Complete series	15.00
Encephalogram	25.00
Foreign body in eye, accurate localization of	25.00

Fluoroscopy for removal of foreign body	5.00
Gall bladder examination	15.00
Gastro-intestinal tract examination by barium meal	25.00
Gastro-intestinal tract examination (complete) by barium meal and barium enema	35.00
Myelogram	25.00
Portable (bedside) in hospital, additional to examination fee	5.00
Pyelogram, intravenous, including cost of dye	20.00
Pyelogram, retrograde	20.00
Skull examination (three views)	15.00
Stomach examination by barium meal	15.00

RADIATION THERAPY

(A schedule of fees for Radiation Therapy has not as yet been established by the department. Until a schedule to cover these procedures has been adopted, bills for radiation therapy will be paid on an individual case basis on recommendation of the medical director.)

Ford Foundation Grants to Hospitals In Ohio Exceed \$11 Million

Checks totalling \$26,080,200 were mailed in June by the Ford Foundation to 959 voluntary, nonprofit hospitals in the 48 states, Alaska, Hawaii and Puerto Rico. Last December the trustees of the Foundation voted \$500 million in grants, allocating \$200 million to hospitals; \$210 million to private colleges and universities to help raise teachers salaries and \$90 million to medical schools to strengthen instruction.

In two previous mailings of checks, in April and May, 2,000 hospitals received nearly \$69 million.

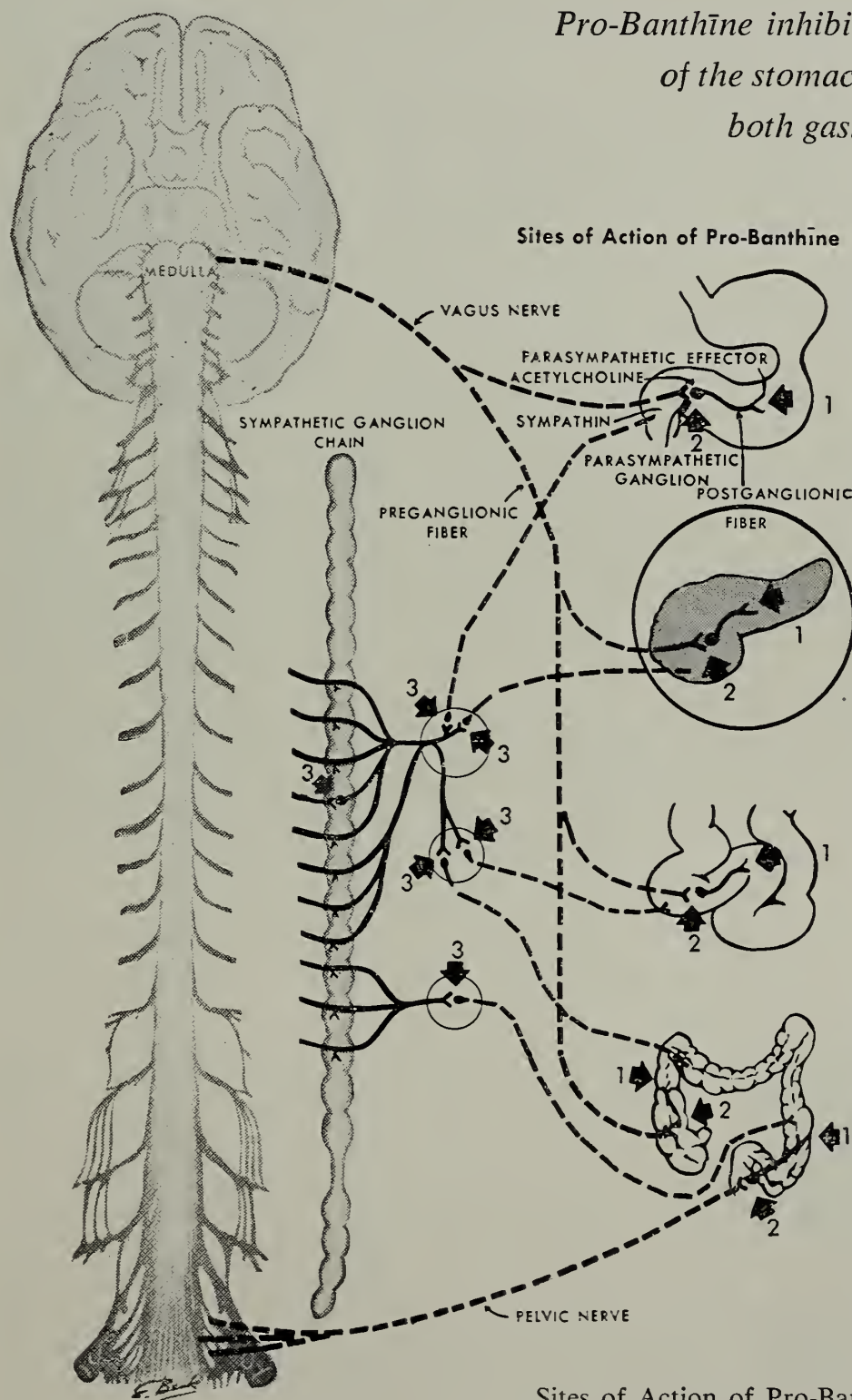
In Ohio the third mailing brought the total distributed in this state to \$5,934,900, shared among 148 hospitals. The amount received by each hospital is half the amount allocated. The remaining half will be mailed in March, 1957, the Foundation states. Total grants to hospitals range from \$10,000 to \$250,000.

Under the terms of the Foundation's hospital program the amount of each grant was determined on the basis of patient days of service and the number of births, as previously reported by the hospital to the American Hospital Association. Each institution will determine for itself how the funds can best be used to help improve and expand its services to the community.

The Foundation states that reports from almost every state attest to major projects under way, or being pushed by various administrators. New buildings, additions, radio-isotope laboratories, research units, air conditioning and many other improvements have been reported. In many instances the grants have been supplemented by local donations to accomplish some desired goal.

Pro-Banthine® Provides Rapid Relief in Acute Pancreatitis

Pro-Banthine inhibits excessive vagal stimulation of the stomach and pancreas and reduces^{1,2} both gastric and pancreatic secretions.



With use of the Levin tube and a drug "such as Pro-Banthine . . . most cases of acute pancreatitis³ will subside in a few hours, or at the most, in a few days."

Schwartz and Hinton achieved⁴ dramatic relief of pain in four of six patients with acute hemorrhagic or edematous pancreatitis within twenty to thirty minutes after giving Pro-Banthine intramuscularly. A dose of 15 to 30 mg. may be repeated¹ parenterally at intervals of six hours.

Pro-Banthine bromide (brand of propantheline bromide) also has proved highly effective in the therapy of peptic ulcer, hypertrophic gastritis, diverticulitis, biliary dyskinesia, ileostomies and genitourinary spasm. G. D. Searle & Co., Research in the Service of Medicine.

1. Jones, C. A.: Arch. Int. Med. 96:332 (Sept.) 1955.
2. Zollinger, R. M.: Postgrad. Med. 15: 323 (April) 1954.
3. Woodward, E. R.: M. Clin. North America 38:115 (Jan.) 1954.
4. Schwartz, I. R., and Hinton, J. W.: Personal communication, February, 1955.

Sites of Action of Pro-Banthine. The principal site of action of Pro-Banthine is on the parasympathetic system where it exerts a dual action while exerting a single and lesser action on the sympathetic system: (1) parasympathetic effector; (2) parasympathetic ganglion; (3) sympathetic ganglion (see arrows).

SEARLE

Revised Code of Ethics Proposed . . .

Final Action on Abbreviated Document But Which Preserved All Basic Principles To Be Taken by AMA House of Delegates at Seattle Meeting

THE Principles of Medical Ethics of the American Medical Association, which have served as a guide for physicians for more than a century, are undergoing radical survey.

The House of Delegates, meeting in Chicago in June, voted in favor of a Reference Committee report which approved a revision of the Principles as prepared by the Council on Constitution and By-laws and endorsed by the Judicial Council. The reference committee and both Councils recommended that final action be deferred until the Seattle Clinical session, November 27-30, "to allow ample opportunity for thorough study on the part of members of the A.M.A."

House action in Chicago followed submission of a report by Dr. Louis A. Buie, chairman of the Council on Constitution and By-laws, which said, among other things, that "there exists a broad twilight zone in which the concepts of ethics and etiquette are entangled and in which there is much overlapping and consequent confusion."

TOO MUCH VERBIAGE NOW

"The present Principles," this report said, "are encumbered by verbosity and qualifying constructions of dubious value which in themselves engender confusion. Hence, it was felt that the Principles should be broad and should provide a framework within which interpretations could be made. They should deal with basic principles which can serve as a ready reference for the busy practitioner."

A salient point in the report said: "It is important to understand that medical ethics are not distinct or separate from ethics generally, but simply emphasize those general principles which are of particular concern to the medical profession. The ethical physician will observe all ethical principles because he realizes that they cannot be enforced by penal reprisals, but must be binding in conscience."

FUNDAMENTALS PRESERVED

The Principles as proposed consist of a brief Preamble and 10 sections which succinctly express the fundamental ethical concepts embodied in the present Principles.

"Every basic principle," the Council report said, "has been preserved. On the other hand, as much as possible of the prolixity and ambiguity which in the past obstructed ready explanation, practical codification and particular selection of basic concepts, has been eliminated."

PROPOSED NEW SECTIONS

The 10 proposed sections follow:

1. The prime objective of the medical pro-

fession is to render service to humanity with full respect for both the dignity of man and the rights of patients. Physicians must merit the confidence of those entrusted to their care, rendering to each a full measure of service and devotion.

2. Physicians should strive to improve medical knowledge and skill, and should make available the benefits of their professional attainments.

3. A physician should not base his practice on an exclusive dogma or a sectarian system, nor should he associate voluntarily with those who indulge in such practices.

4. The Medical profession must be safeguarded against members deficient in moral character and professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

5. Except in emergencies, a physician may choose whom he will serve. Having undertaken the care of a patient, the physician may not neglect him. Unless he has been discharged, he may discontinue his services only after having given adequate notice. He should not solicit patients.

6. A physician should not dispose of his services under terms or conditions which will interfere with or impair the free and complete exercise of his independent medical judgment and skill or cause deterioration of the quality of medical care.

7. In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him to his patient.

8. A physician should seek consultation in doubtful or difficult cases, upon request or when it appears that the quality of medical service may be enhanced thereby.

9. Confidences entrusted to physicians or deficiencies observed in the disposition or character of patients, during the course of medical attendance, should not be revealed except as required by law or unless it becomes necessary in order to protect the health and welfare of the individual or the community.

10. The responsibilities of the physician extend not only to the individual but also to society and demand his cooperation and participation in activities which have as their objective the improvement of the health and welfare of the individual and the community.

Dysmenorrhea:

"one third of all young women in America are afflicted with it."¹

Edrisal^{*}

A day or so before menstruation begins,
prescribe 'Edrisal' for dysmenorrhea.

Two tablets every 3 hours

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¹ M. Times 76:416.

^{*}T.M. Reg. U.S. Pat. Off.



State Medical Board Examinations . . .

June Examinations Are Taken by 408 Graduates of Medical Schools Seeking Licenses in Ohio; List of Questions Asked M.D.'s Given

THE State Medical Board of Ohio gave examinations on June 14, 15 and 16 to 408 graduates of Medical Schools who are candidates for licenses to practice medicine and surgery in the State, Dr. H. M. Platter, Secretary, announced.

In addition examinations were given to 44 persons seeking licenses to practice osteopathic medicine and surgery. In the limited practice fields, examinations were given to 9 chiropractors, 15 mechanotherapists, 45 chiropractors, 37 masseurs and 5 cosmetic therapists.

Results of the examinations will be announced following a meeting of the Board on August 28.

Following are the questions given to doctors of medicine:

ANATOMY

1. Head and Neck:
The posterior boundary of the Anterior Triangle of the neck is the (1)..... In the Carotid Sheath, the Vagus Nerve lies (2)..... and (3)..... to the Common Carotid Artery. The only deep fascia found in the face is the (4)..... The hemispheres of the cerebelli are separated by the (5)....., a projection of the (6)..... The smallest of the cranial nerves is the (7)....., which innervates the (8)..... and passes out of the cranial cavity via the (9)..... The point of termination of the nervous portion of the retina is known as the (10).....
2. Thorax and Back:
The afferent (sensory) supply to the skin of the thorax travels over the (11)..... of the thoracic spinal nerves and has its deep origin in the (12)..... The lower right interspaces are drained (venous) by the (13)..... The contracture impulse of the heart is carried from Atrio-Ventricular Node to the Purkinje Fibers via the (14)..... Preganglionic Sympathetic Fibers are known as (15)..... and are given off by all Thoracic Spinal Nerves and the first (16)..... Lumbar Spinal Nerves. The pulmonary tract from the nasal cavity through the Trachea is lined histologically with (17)..... The (18)..... is a cartilagenous ridge formed by the bifurcation of the trachea. The Triangle of Auscultation is bounded below by the (19)..... The Serratus Posterior Muscle is innervated by the (20)..... as well as spinal nerves.
3. Abdomen:
The suspensory ligament of the Penis arises from (21)..... fascia, while the fundiform ligament of the Penis arises from (22)..... fascia. The Cremaster Muscle arises from the (23)..... The (24)..... and (25)..... muscles form the inferior boundary of the abdomen. Meckle's Diverticulum is a remnant of the fetal (26)..... The large diverticulum, given off by the peritoneal cavity, is the (27)..... and it communicates with the cavity through the (28)..... A fibrous, muscular band, the (29)..... holds the duodenal-jejunal flexure in place. The caudate lobe of the Liver is located between the (30)..... on the right and the (31)..... on the left. Of the two hepatic ducts, the (32)..... is the larger. The hepatic ducts join to form the (33)..... Of the two kidneys, the (34)..... is the more superior. The (35)..... is the primary functional unit of the kidney.
4. The Upper Extremity:
The Radio-Carpal Articulation is a (36)..... type joint. Abduction of the Arm (Brachium) is managed by the (37)..... and (38)..... muscles. The nerve whose innervation serves as the "spreader-approximator" of the fingers is the (39)..... The Basilic Vein lies (40)..... to the Cephalic Vein. The Median Nerve lies (41)..... to the Brachial Artery in the Antecubital Fossa. The Lumbrical Muscles arise from the (42).....
5. The Lower Extremity:
The (43)..... and (44)..... muscles form the third layer of Plantar Muscles. The Sural Nerve accompanies the (45)..... on the posterior aspect of the leg. The medial boundary of Scarpa's Triangle (Femoral Trigone) is the (46)..... After leaving Scarpa's Triangle, the Femoral

Artery is contained in (47)..... The Ligamentum Teres Femoris is attached to the (48)..... of the Femur. The Popliteal Fossa is bounded laterally and above by the (49)..... The Patella is formed in the (50).....

PHYSIOLOGY

1. Briefly describe the condition known as crush syndrome.
2. Discuss the significance of sedimentation time.
3. Give the functions of thyroid gland.
4. (a) In what condition is the pulse pressure increased? Decreased? (b) What is the normal range of pulse pressure in mm. of mercury?
5. State the function of (a) ovary; (b) Prostate gland; (c) Vas deferens.
6. Give the function of the cerebellum.
7. Name five conditions which increase the amount of solids in urine.
8. What is hypoglycemia and give symptoms of same.
9. Briefly describe the process of segmentation of the ovum.
10. What are the Wolffian bodies? When do they appear and into what organs do they develop?

BACTERIOLOGY

1. List the stages in the life cycle of the Trichina spiralis.
2. List the diseases which are frequently diagnosed by agglutination tests.
3. In what anatomic areas does Monilia albicans commonly produce infection.
4. List the damaging effects of infection with Corynebacterium diphtheriae.
5. List the types of injury or disease produced by staphylococci.

DIAGNOSIS

1. A man, 40 years of age and previously healthy, was punched in the precordium. Sixteen days later, he had an increased temperature and a feeling of oppression and pain behind the sternum. On the 21st day, he was admitted to the hospital. His pulse was quick, of varying strength and irregular; cardiac dullness increased greatly. He died on the 40th day after the trauma in a septic condition. Give your diagnosis of the above case.
2. A white woman, 48 years old, was admitted to the hospital because of a fractured left tibia and fibula. Six weeks after the accident, the union appeared perfect but there was a moderate amount of edema of ankle and leg. Massage was prescribed. Two days later, she died suddenly. Give your diagnosis of this case.
3. Can thrombosis of the veins cause pulmonary embolism?
4. A woman was kicked in the abdomen by a horse. Sequence of events—shock; then hard abdomen; pulse 140; temperature 104 degrees; vomiting and constipation. State your diagnosis.
5. Boy, coasting down hill wrapped around a tree. Events: pale; weak; cold sweat; pulse 106; temperature 97 degrees; WBC 12,000; RBC 2,400,000; some abdominal distension; no abdominal pain or soreness. State diagnosis.
6. State causes of diabetes mellitus and diabetes insipidus.
7. How long after complete obstruction of ureter will a kidney come back to function again?
8. What do you understand by angina pectoris, and cause?
9. Give three causes of hematuria.
10. What condition with periodic attacks must be differentiated from gall bladder disease?

CHEMISTRY

1. Define glycogen. Discuss in relation to metabolism of glucose.
2. Discuss the Fate of ingested protein in the stomach and small intestine.
3. Discuss briefly any three (3) of the following: (1) pH of intestinal contents; (2) creatinuria; (3) ferritin; (4) urobilinogen.
4. List five (5) derivatives of hemoglobin which have clinical importance.
5. When should gastric analysis be performed, and which test should be used?

MATERIA MEDICA AND THERAPEUTICS

1. (a) Define Chemotherapy. (b) Define antibiotic.
2. Draw a diagram showing the role of acetylcholine and epinephrine in the autonomic nervous system.

(Continued on Page 868)

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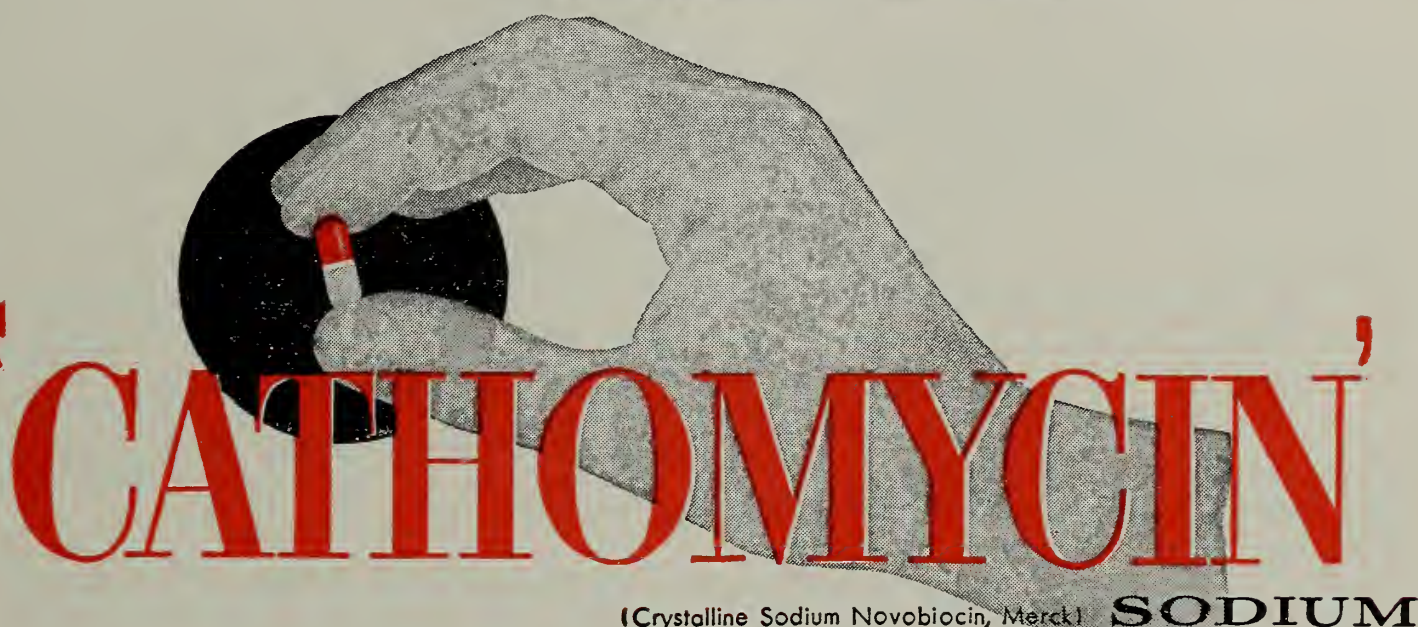
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3. Give the pharmacologic action and three therapeutic uses of neostigmine bromide.
4. Give the toxic manifestations of digitalis.
5. Give the principal actions of Vitamin D.
6. Give the mechanism of action of the heterocyclic sulfonamides as diuretics (acetazolamide or Diamox).
7. Compare the analgesic effect of codeine, morphine and meperidine (demorol).
8. What is the effect of alcohol upon the central nervous system?
9. Give 5 general principles in the treatment of amebiasis.
10. Give schedules for immunization to the common infectious diseases: (a) Diphtheria; (b) Pertussis; (c) Tetanus; (d) Smallpox.

PRACTICE

1. Give the clinical symptoms of pancreatic insufficiency.
2. Give the symptoms and complications of typhoid fever.
3. Name 3 diseases due to toxin producing bacteria.
4. Give the etiology and manifestations of moniliasis.
5. Give the clinical picture of adrenal cortical hyperfunction.
6. Give prognosis and treatment of paraganuloma type of Hodgkin's disease.
7. Outline treatment of stomach hemorrhage (repeated).
8. Give treatment of acute hepatitis.
9. Give treatment of toxic adenomatous goitre.
10. Give indications for large doses of B₁₂ (500 micro).

PATHOLOGY

1. List the important causes of lung abscess.
2. List the important complications of myocardial infarction.
3. List the important sequelae of cirrhosis of liver.
4. List the renal changes of malignant hypertension.
5. List the findings in Cushing's syndrome.
6. List the usual routes of metastasis of carcinoma of the breast.
7. List the possible causes of disseminated destructive lesions of bone.
8. List the spinal fluid findings in tuberculous meningitis.
9. List the important hematologic and physical findings in chronic myeloid leukemia.
10. List three important causes of constriction in the rectosigmoid area.

SURGERY

1. Give the treatment of a patient about 50 years of age admitted to the hospital with severe epistaxis and giving a history of severe hypertension over a period of 5 or more years.
2. Give the diagnosis and treatment of simple fracture of both bones of the forearm.
3. Give the etiology, symptoms, diagnosis, and treatment of sub-diaphragmatic abscess.
4. Give the symptoms and diagnosis of acute cholecystitis.
5. Give the symptoms and diagnosis of carcinoma of caecum.
6. Differentiate scrotal hernia from hydrocele.
7. Differentiate acute appendicitis from twisted ovarian cyst.
8. Give the treatment of fractured patella.
9. Differentiate cerebral compression, contusion and concussion.
10. Give the indications for amputation of an extremity.

OBSTETRICS AND GYNECOLOGY

1. Discuss the conditions which must be fulfilled before forceps can be applied.
2. Outline proper pre-natal care with attention to all phases that are important.
3. Give symptoms, causes and treatment of tubal pregnancy.
4. Outline diagnosis and treatment of acute salpingitis.
5. Give causes and treatment of sterility.
6. Describe the anatomical supports of the uterus.
7. Discuss the care of the premature infant.
8. Discuss the management of Placenta Praevia (a) Centralis; (b) Marginalis.

9 & 10. True or False?

- (a) Occiput posterior presentations usually result in prolonged labor.
- (b) Pfeiffer forceps are designed for use on the after-coming head in breech deliveries.
- (c) A tense painful uterus in the last trimester of pregnancy associated with shock is usually due to abruptio placentae.
- (d) A platypelliod pelvis has an anterior posterior diameter smaller than that of the normal.
- (e) In an incubator for premature babies, a surplus or high saturation of oxygen is desirable.
- (f) Primary dysmenorrhea may be caused by a neurosis, notably hysteria.
- (g) Mittelschmerz is a term used to designate periodic intermenstrual pain.
- (h) Colpitis is an inflammation of the vaginal tube.
- (i) The true conjugate is not important in pelvimetry.
- (j) The gynecoid pelvis is the one most often found in South America.

SPECIALTIES

1. A woman, age 31, has been in an auto accident and her ribs and pelvis have multiple fractures. What are the urological problems that may arise and how would you handle them?
2. Discuss the etiology, appearance and treatment of: (a) Psoriasis; (b) Neurodermatitis.
3. How can you differentiate between allergic and infectious rhinitis?
4. Describe lymphogranuloma venereum causative organism and treatment.
5. True or False?
 - (a) Conjunctival infection is not influenced by adrenalin (epinephrine).
 - (b) In primary glaucoma, atropine is indicated.
 - (c) A myotic causes stimulation of the iris.
 - (d) A ciliary sphincter is pericorneal.
 - (e) A chalazion is a meibomian cyst.

PREVENTIVE MEDICINE & HYGIENE

1. What are the most common economic and medical causes of infant mortality? Give preventive measures for each.
2. Give the principal elements required for a comprehensive public health program.
3. Discuss the epidemiology of typhoid fever.
4. Give cause, source of infection and measures for prevention of "Athlete's Foot."
5. What measures are practical and desirable for the prevention of the dissemination of disease by food handlers?

Fall American College of Surgeons Program Planned in San Francisco

What promises to be the world's largest meeting of surgeons is scheduled in San Francisco, Calif., when the American College of Surgeons holds its 42nd annual Clinical Congress, October 8-12. More than 10,000 physicians, students and related medical personnel are anticipated.

For the first time, student representatives from 16 medical schools will attend the Clinical Congress at College expense. This year and in the future schools will participate in rotation depending upon the geographic location of the meeting.

Detailed information may be obtained from the American College of Surgeons, 40 E. Erie Street, Chicago 11, Ill.

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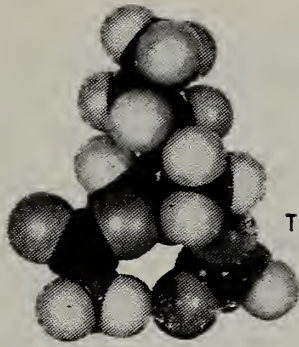
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Hospital Accreditation . . .

Program Given Thorough Airing at Recent AMA Meeting; Conclusions And Principles Enumerated by Special House Committee Are Adopted

THE House of Delegates of the American Medical Association during the June, 1956, Annual Meeting in Chicago adopted a set of recommendations concerning the National Hospital Accreditation Program.

The recommendations were initiated by the "Stover Committee." This committee, actually titled "The Committee to Review the Functions of the Joint Commission on Accreditation of Hospitals," had been appointed by the Speaker of the House of Delegates of the AMA in accordance with a resolution adopted the previous year. Its chairman was Dr. Wendell C. Stover a delegate from Indiana.

Ohio's delegates arrived at the convention with a resolution on the subject of hospital accreditation, drafted May 13 by the OSMA Committee on Hospital Accreditation; and approved by Council, June 2. (See July issue of *The Ohio State Medical Journal*.)

COVERED OHIO RESOLUTION

During the hearings before the Reference Committee on Medical Education and Hospitals at the AMA meeting, it became apparent, in the opinion of the Ohio delegates, that the sense of the Ohio resolution, which was introduced by Dr. L. Howard Schriver of Cincinnati, was covered by the "Stover Report." It was therefore decided that it was unnecessary to push for adoption of the Ohio resolution.

The "Stover Committee" met five times during the year with all seven members present. Information was obtained by mail and by interviews with officers of state and national medical organizations, hospital associations and staff members of the Joint Commission.

CONCLUSIONS ADOPTED

Its conclusions as amended and adopted by the House of Delegates follow:

"1. Accreditation of hospitals should be continued.

"2. The Joint Commission should maintain its present organizational representation.

"3. The Board of Trustees should report annually to the House of Delegates on the activities of the Joint Commission.

PHYSICIANS SHOULD BE ON BOARD

"4. Physicians should be on the administrative bodies of hospitals.

"5. General practice sections in hospitals should be encouraged.

"6. Staff meetings required by the Joint Commission are acceptable, but attendance requirements should be set up locally and not by the Commission.

"7. The Joint Commission should not concern itself with the number of hospital staffs to which a physician may belong.

SHOULD NOT BE PUNITIVE

"8. The Joint Commission is not and should not be punitive.

"9. The Joint Commission should publicize the method of appeal to hospitals that fail to receive accreditation.

"10. Reports on surveys should be sent to both administrator and chief of staff of hospital.

SELECTION OF SURVEYORS

"11. Surveyors should be directly employed and supervised by the Joint Commission.

"12. Surveyors should work with both administrators and staff.

"13. New surveyors should receive better indoctrination.

"14. Blue Cross and other associations should be requested not to suspend full benefits to non-accredited hospitals until those so requesting have been inspected.

EDUCATIONAL CAMPAIGN

"15. The American Medical Association should conduct an educational campaign for doctors relative to the functions and operations of the Joint Commission.

"16. The Committee also suggests that the American Medical Association and the American Hospital Association encourage educational meetings for hospital boards of trustees and administrators either on state or national levels to acquaint these bodies with the functions of accreditation.

REGARDING STAFF PRIVILEGES

The House approved a reference committee suggestion that the following statement be added to strengthen the report:

"The Committee recommends that the commissioners to the Joint Commission on Accreditation of Hospitals, appointed by the Board of Trustees of the American Medical Association, urge that Commission to study:

"1. The problems of the exclusion from hos-

pitals and arbitrary limitation of the hospital privileges of the general practitioner, and

"2. Methods whereby the following stated principles may be achieved:

"The privileges of each member of the medical staff shall be determined on the basis of professional qualifications and demonstrated ability.

"Personnel of each service or department shall be qualified by training and demonstrated competence, and shall be granted privileges commensurate with their individual abilities."

Competitive Athletics in Schools Is Subject of Pediatrics Report

With the announced purpose of aiding physicians in their roles as advisors to parents, educators, community leaders and others, the American Academy of Pediatrics has issued a comprehensive statement of policy on the subject, "Competitive Athletics."

The statement is a report of the Academy's Committee on School Health, of which Dr. Thomas E. Shaffer, Columbus, is a member. The subject is considered under such headings as age, sex, competition, athletics, programs, physical aspects, emotional aspects and leadership.

The report takes into consideration a fund of information as to the effects of organized competitive athletic programs among children from the experience and investigation of recognized leaders in education and recreation as well as from physicians.

Reprints may be obtained from the American Academy of Pediatrics, 1801 Hinman Ave., Evanston, Ill.

Ohio Department of Health Sponsors Industrial Nurses Institute

The Ohio Department of Health, with the cooperation of the Ohio State Nurses Association and the Ohio Industrial Nurses Association, is sponsoring the Regional Industrial Nurses Institute at Youngstown University, Youngstown, September 15-22, the first such regional meeting of this nature.

There will be a dinner on both Saturdays to which industrial physicians and management are invited. Nationally known speakers will participate in the program. Additional information may be obtained from, or registrations made with Dr. Thomas F. Mancuso, chief of the Division of Industrial Hygiene, Ohio Department of Health, Columbus 15, Ohio.

Guide dogs, obtained at no cost to them or the government, are being used by approximately 10 per cent of the more than 2,000 World War II veterans who have lost their sight, Veterans Administration reported.

Do You Know? . . .

Dr. Claude S. Perry, Columbus, spoke on "Ophthalmological Problems in Schools for the Blind," at a general session during the 43rd Biennial Convention of the American Association of Instructors of the Blind, held at The Ohio State School for the Blind, Worthington, June 24-28.

* * *

Dr. Leon Goldman, head of the Department of Dermatology, University of Cincinnati, announced receipt of two grants totalling \$33,780 from the National Institutes of Health for work on skin diseases in his department. The grants will continue a study of the value and limitations of hydrocortisone and its derivatives in direct use on the skin and support a study in occupational dermatitis.

* * *

Dr. A. Ashley Weech, director of the Cincinnati Children's Hospital Research Foundation and medical director of the hospital, received the 1956 Borden Award, highest honor of the American Academy of Pediatrics, which includes a gold medal and \$1,000. The award was made largely on the basis of Dr. Weech's nutritional studies.

* * *

Dr. Gordon M. Meade has been appointed clinical director of the Miners Memorial Hospital Association, the chain of 10 hospitals serving beneficiaries of the United Mine Workers Welfare and Retirement Fund in Virginia, West Virginia and Kentucky. He will succeed Dr. Aims C. McGuinness who, after recruitment and organization of the hospital medical staffs, will return to private practice.

* * *

Almost 70 per cent of the American population at ages 15 and over is married now, whereas for the decades prior to World War II the proportion was little more than 60 per cent.—Metropolitan Life.

* * *

Dr. Jonathan Forman recently addressed the Regional Rural Life of Catholic Clergy at Carey on the subject of "Health."

* * *

On August 31 Dr. Leonard Scheele will end his career of 23 years with the U. S. Public Health Service, the last eight as Surgeon General, to accept a position with Warner-Lambert Pharmaceutical Company. Dr. Scheele was re-appointed last April to a third four-year term. Indications in Washington were that his successor would not be chosen immediately.

* * *

George H. Saville, Director of Public Relations, Ohio State Medical Association, has been appointed by the Board of Trustees of the American Medical Association to serve on the eight-member advisory committee to the Director of Public Relations of the AMA.

In Our Opinion:

Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

LEGAL ASPECTS OF WORK OF TISSUE COMMITTEE

Maintenance of a tissue committee has become one of the major requirements of a well-run, modern hospital. Obviously, the question frequently arises: What are the legal aspects of the work of such a committee, especially in relation to charges and suits for alleged malpractice?

The point is discussed at length in an article, "The Tissue Committee," appearing in the *Medicine and the Law* Department of the April 7, 1956, issue of *The Journal of the AMA*.

The concluding paragraph summarizes the subject adequately, reading as follows:

"As long as tissue committees continue to operate as training aids, deal only in case numbers, maintain tabular rather than narrative conclusions, and make only general medical findings rather than specific findings of individual negligence, it is doubtful that the reports of their activities will be admissible in evidence against a staff member charged with malpractice."

LOTS OF LOOSE TALK ABOUT LOBBYING

In a recent issue of *Washington Report* of the U. S. Chamber of Commerce, Milton Smith, associate general counsel of the organization, discussed the recent flurry in Congress on regulating so-called lobbyists. Smith intimates there has been a lot of loose talk. You'll be interested in what he thinks for you as members of the Ohio State Medical Association are being asked, and will continue to be asked, to express your views to your Congressmen on medical and health proposals and on other measures of direct interest to physicians. Smith's comments follow:

"There has been a lot of loose talk about regulating 'lobbyists.' Most of it overlooks the fact that we still have a Federal Constitution.

"That Constitution guarantees rights of speech and petition.

"Several times in the past few years the Supreme Court has tried to give Congress an elementary lesson on the First Amendment.

"One was when a congressional investigating committee cited a man for contempt for refusing to disclose persons who had purchased books or pamphlets from him.

"A little later the Court outlawed 1946 Lobby Regulation Law provisions which called for reporting of publications, news releases, and other informational material bearing on legislative issues.

"Even in holding that persons engaged in 'direct lobbying' could be required to submit reports to Congress, the Court carefully pointed out that this did not impose prior restraints on rights of speech or petition.

"Many disagree even with this view; three

Supreme Court Justices said this limited regulation impinged on constitutional rights. The plain fact, nevertheless, is that aside from recognized sanctions on corruption and bribery, Congress has no authority to 'proscribe' lobbying or lobbyists.

"That there may be some misunderstanding about this is suggested by the report just released of the Select Senate Committee investigating campaign expenditures.

"Recommending a 'complete study of the Federal Lobbying Act,' the Committee commented:

"The language of the present act is drawn so loosely as to make it difficult for even the best intentioned citizen to determine permissible and proscribed areas of activity. . . ."

"The seeming implication that there is something wrong with the law because it does not 'proscribe' lobbying is startling.

"One can only hope that Congress will not waste time on laws to 'permit and proscribe' the right of petition.

"To suggest that any organization of American citizens must get permission before it can speak for its members is to scorn the Bill of Rights."

MORE V. A. BEDS THAN NEEDED FOR SERVICE-CONNECTED CASES

The AMA has pointed out, in explaining its policy concerning the care of veterans with non-service-connected illnesses, that there were enough beds twenty years ago in VA hospitals to take care of all service-connected cases. Additions during the past two decades have merely added beds for the non-service-connected. Here is some substantiating testimony, from Mr. Higley, Administrator of Veterans' Affairs.

Testifying before the House Committee on Veterans' Affairs at a hearing on "Replacement and Modernization of Veterans' Administration Hospitals," Mr. Higley said:

". . . if you have an extra bed you are not using, and if you have a veteran, non-service-connected, who needs hospitalization, and he cannot afford to pay for that hospitalization, then we are automatically to take him in. That is the law as it exists today. But it is predicated entirely, you will note, on if we have extra beds. That is the whole essence of it.

"Now, we find ourselves today in the situation of operating about 100,000 patients in our own hospitals, and on any given day over a third of them are service-connected and two-thirds of them are non-service-connected. We do not need to go into a lot of detail, but that is approximately the situation.

"So, just putting it bluntly, that is the situation. If you add on any appreciable number of beds, either as a big addition or as a big hospital, you are building beds for non-service-connected, whereas the law as it exists today actually says you will only take in non-service-connected when you have extra beds, when there are beds that you do not need for service-connected.

"So I think there is a fundamental question

that has got to be answered here pretty soon. Is it the will of Congress and the American people that we will build beds for non-service-connected? Because if you add on any hospital, you can pretty well argue that you are pretty much adding beds on for the non-service-connected. Because we have very ample space, far more than we need at the present time, for all service-connected." (page 2287, official report of hearing)

At the same hearing, Dr. Wolford, Deputy Chief Medical Director of the VA, reported that the future service-connected load in VA hospitals is estimated at a maximum of 41,000, carrying projections as far ahead as the year 2000 (based on current conditions and eligibility requirements).

In other words, for almost 50 years in the future, the VA will need only about one-third of its present beds for service-connected cases.

OFFER TO ASSIST VOCATIONAL COUNSELORS

Professional organizations should cooperate with vocational counselors of the secondary schools in stimulating interest on the part of pupils in the educational and health professions, the Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association states.

The Ohio State Medical Association is ready to meet such requests.

Vocational counselors who need advice or material pertaining to opportunities in the health professions should contact the Columbus Office of the Association.

NEW NAME BUT SAME OLD POLICY

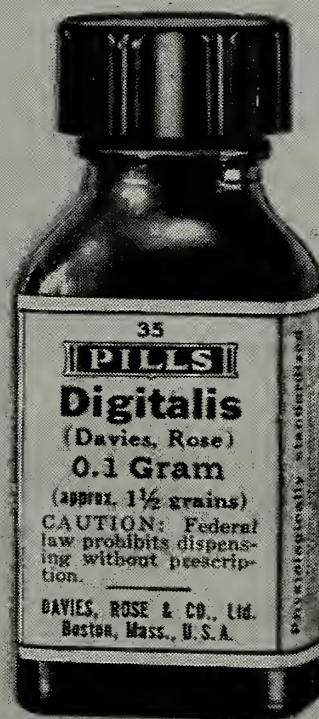
If there was any question about it, the AFL-CIO as a joint organization favors national compulsory health insurance, as each group did before the merger. The AFL-CIO stand was taken officially for the unions by Nelson Cruikshank in testimony before the House Ways and Means Committee on a bill for increased payments for the medical care of public relief recipients.

GOOD BOOKLET FOR THOSE IN INDUSTRIAL PRACTICE

Physicians engaged in industrial practice have found the AMA Council on Industrial Health's new booklet on guides and procedures for industrial nurses to be a big time saver. Titled, "Guiding Principles and Procedures for Industrial Nurses," the booklet contains sections on qualifications, functions, relationships and responsibilities of industrial nurses as well as standard procedures to follow. This 36-page booklet allows space for the physician to insert preferred or alternative instructions. Single copies are available free of charge from the AMA Council. Quotations on quantity prices may be obtained from AMA's Order Department.

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In Memoriam . . .

Elmer A. Curry, M. D., Eaton; Miami Medical College, Cincinnati, 1903; aged 93; died June 3; member of the Ohio State Medical Association through 1939. Dr. Curry was a practicing physician in Cincinnati until 1940 when he retired from professional work. He had since been presented the 50-Year Pin of the Ohio State Medical Association. He made his home for several years at Gettysburg, later moving to Eaton where he resided with a niece.

Henry Engel, M. D., Dover; University of Munich, 1907; aged 74; died June 5; member of the Ohio State Medical Association and the American Medical Association; Dr. Engel moved to this country from Germany in 1938 and had been a practicing physician in Dover for about 18 years. He is survived by his widow, three sons and a brother.

Frank J. Geib, M. D., Route 1, Chagrin Falls; Harvard University Medical School, 1899; aged 83; died June 21; member of the Ohio State Medical Association through 1948; recipient of the State Association's 50-Year Award. Dr. Geib practiced medicine in Cleveland from 1900 to 1941 when he relinquished most of his professional work. He was a member of the Pasteur Club, the Cleveland Medical Library and Sigma Alpha Epsilon. Survivors include a son and a daughter.

Albert H. Gellenbeck, M. D., Cincinnati; University of Cincinnati College of Medicine, 1933; aged 58; died June 13; member of the Ohio State Medical Association. A practicing physician in Cincinnati and the Northside area for many years, Dr. Gellenbeck was a veteran of World War I. He was a member of the Catholic Church and the Knights of Columbus. Survivors include his widow, a daughter, a son, three sisters and three brothers.

Edward C. Goldcamp, M. D., Youngstown; Jefferson Medical College of Philadelphia, 1914; aged 67; died June 2; member of Ohio State Medical Association through 1949; diplomate of the American Board of Otolaryngology. Dr. Goldcamp did several years of graduate work after receiving his medical degree. During World War I, he entered the Army Medical Corps and attained the rank of major. After the war he practiced for five years in Warren and then moved to Youngstown. He was a member of the Youngstown Club, the Youngstown Country Club and the Catholic Church. Dr. Stephen W. Goldcamp and Dr. John S. Goldcamp, both of Youngstown, are brothers. Another brother and a sister also survive.

Hardie F. Harris, M. D., Cleveland; Meharry Medical College, 1905; aged 74; died June 3. Dr. Harris had been a practicing physician in Cleve-

land for about 30 years. He was a member of the Methodist Church. Survivors include his widow, a son, and two daughters.

Theodor C. G. Herwig, M. D., Akron; University of Goettingen, Prussia, 1924; aged 62; died June 20; member of the Ohio State Medical Association, the American Medical Association and the American College of Chest physicians. Dr. Herwig came to this country in 1924 and after taking intern work in Cleveland moved to Akron. He was first married to Dr. Frances K. Herwig, now of Ravenna. Also surviving are his widow by a second marriage, a son, a step-son and a step-daughter; also other relatives in Germany.

Charles R. King, M. D., Toledo; Toledo Medical College, 1907; aged 70; died June 22; member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Surgeons; member of the American Academy of Ophthalmology and Otolaryngology. A native of Whitehouse in Lucas County, Dr. King practiced there for a short time before he moved to Toledo after taking graduate work. During World War I he served with the Army Medical Corps. For 16 years he served as a member of the University of Toledo's Board of Directors. Organizations to which he belonged included the Masonic Lodge, the Elks Lodge, and the National Amateur Press Association. A sister survives.

Arthur J. Light, M. D., Cincinnati; Medical College of Ohio, Cincinnati, 1908; aged 71; died June 12; member of the Ohio State Medical Association and the American Medical Association. Dr. Light was a practicing physician in the Cincinnati area for more than 45 years. He was a member of the Masonic Lodge and a past-president of the Sertoma Club. Survivors include a daughter and a sister.

Robert D. Myers, M. D., Columbus; Ohio State University College of Medicine, 1926; aged 55; died June 19; member of the Ohio State Medical Association, the American Medical Association and the American Society of Anesthesiologists. A practicing physician in Columbus, Dr. Myers was associated with the staff of Mt. Carmel Hospital. He was a veteran of World War II, having served with the Medical Corps. Affiliations included memberships in several Masonic bodies, Pi Kappa Alpha, Alpha Kappa Kappa and the Evangelical & Reformed Church. Surviving are his widow and three sons.

C. Kendal Neher, M. D., Cleveland and Lakewood; University of Chicago School of Medicine, 1934; aged 51; died June 24 in an airplane accident; member of the Ohio State Medical Association and the American Medical Association.

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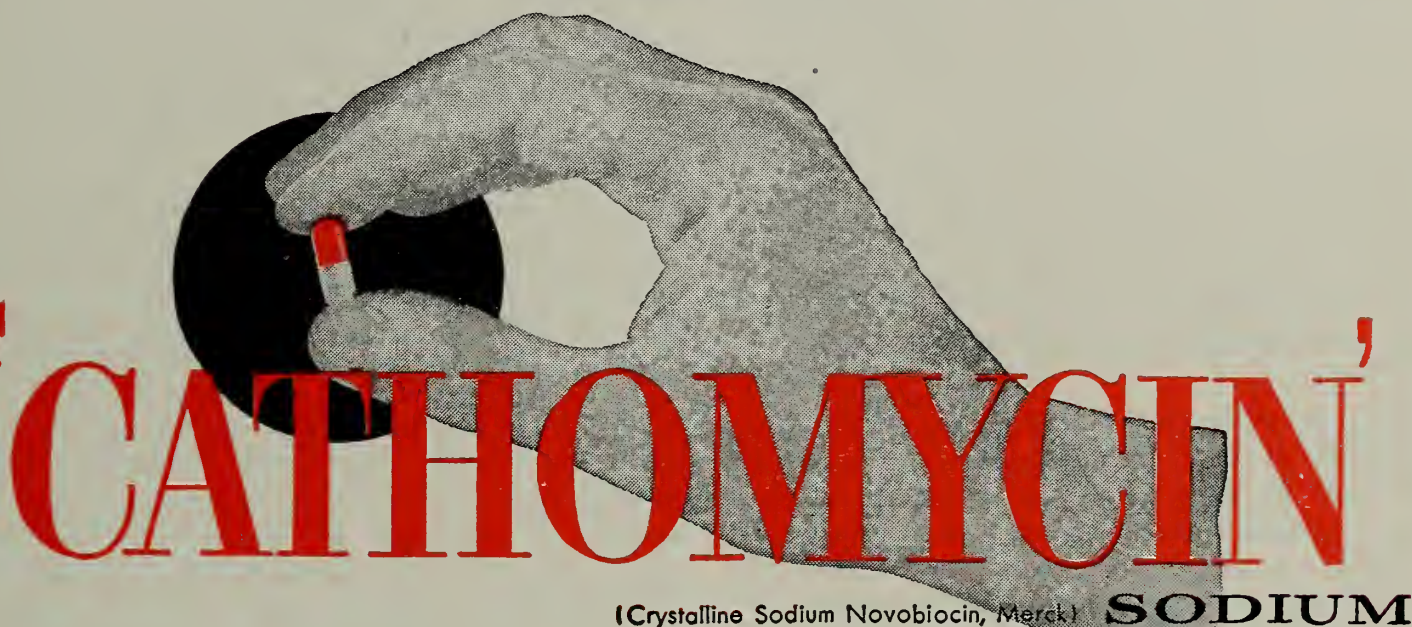
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tion. Dr. Neher had been a practicing physician in Cleveland for about 15 years. He had previously practiced in Indiana, Illinois and Michigan. Survivors include his widow, three daughters, a sister and a brother, Dr. Lauren M. Neher, of Jerome, Ind.

Orrin H. Nihart, M. D., Edon; Starling Medical College, Columbus 1898; aged 84, died May 29 at his winter home in Florida; member of the Ohio State Medical Association through 1952 and recipient of the Association's 50-Year Award. Dr. Nihart was a native of Williams and served virtually all of his professional career in the Edon area. During his early years he served as county coroner and as county representative to the State Legislature. A daughter survives.

John Otis, M. D., Cleveland; Western Reserve University School of Medicine, 1943; aged 44; died June 10 as the result of a double shooting involving himself and his wife; service member of the American Medical Association; member of the American Psychiatric Association; diplomate of the American Board of Psychiatry and Neurology. Dr. Otis served with the Army Medical Corps during World War II. He had been on the staff of the Crile Veterans Administration Hospital since 1947. Survivors include a son and daughter, his mother, a sister and a brother.

Wade R. Portz, M. D., Hartville; Ohio State University College of Medicine, 1929; aged 53; died June 23 in a drowning accident; member of the Ohio State Medical Association, the American Medical Association, the American and Ohio Academies of General Practice. Dr. Portz had been a practicing physician in the Hartville area for many years. Survivors include his widow, a daughter, three sisters and a brother.

Leonard A. Stack, M. D., Lorain (Vermilion); University of Cincinnati College of Medicine, 1923; aged 57; died June 19; member of the Ohio State Medical Association, the American Medical Association and Fellow of the American College of Surgeons. A native of Lorain, Dr. Stack served all of his professional career in Lorain and vicinity. He had been making his residence in recent years at the neighboring Vermilion Lagoons area. A veteran of both World Wars, he served with the Army in World War I and with the Medical Corps of the Navy during World War II. In addition to his professional work, Dr. Stack was a yachting enthusiast; recently served as commodore of the Inter-Lakes Yachting Association and was a member of the Lorain, Vermilion Yacht Clubs and the Vermilion Boat Club. He was also a member of the Moose Lodge, the Kiwanis Club and the Catholic Church. Surviving are his widow, a daughter, three sons, three sisters and three brothers, one of whom is Dr. Robert A. Stack, of Lorain.

Otto Arnold Vornholt, M. D., Gallipolis; Hahnemann Medical College and Hospital of Chicago, 1919; aged 65; died June 13; member of the Ohio State Medical Association, the American Medical Association and Fellow of the American College of Surgeons. A practicing physician and surgeon in the Gallipolis area since 1921, Dr. Vornholt played a vital role in the development of the Holzer Hospital and Clinic. He was a member of the Methodist Church, the Elks Lodge and the Gallipolis Golf Club. Survivors include his widow, two daughters, a son, two sisters and a brother. Dr. Charles E. Holzer, Sr., is a brother-in-law.

Philip Zenner, M. D., Cincinnati; Miami Medical College, Cincinnati, 1875; aged 104, died June 25; member of the Ohio State Medical Association, the American Medical Association and the American Neurological Association. Dr. Zenner not only held the distinction of being the oldest member of the Ohio State Medical Association, but is remembered for a distinguished career in the Cincinnati area, where he was in active practice for more than 60 years.

A native of Cincinnati, where his father was in the mercantile business, he graduated from Ohio University, Athens, at the age of 18, at a time when many Civil War veterans were going through college on early GI educational benefits. After receiving his medical degree from the Miami Medical College and practicing for four years, he went abroad for graduate study principally in psychiatry and neurology. Upon his return to Cincinnati he became lecturer and later professor in the Ohio Medical College and in later years retained the title of emeritus professor in neurology in the University of Cincinnati. Dr. Zenner was a charter member of the staff of Jewish Hospital, a post from which he retired in 1947. He was one of the founders of the charter government of Cincinnati and took active part in many civic enterprises. He wrote many articles for American and European medical journals. A pioneer in advocating more practical sex education for teenagers, he wrote a book which was used in the Cincinnati schools for many years. Although in ailing health for the past year or more, until he was well past the age of 102 Dr. Zenner went about the city at will, voted and took other active interest in current affairs. A bachelor, Dr. Zenner is survived by nephews and cousins.

* * *

Special Committee Presents Memorial To Dr. William M. Skipp

At the behest of the House of Delegates of the Ohio State Medical Association a special committee was appointed to draft a suitable resolution with regard to the untimely death of the late Dr. William M. Skipp, Youngstown, former President of the Association and long-time member of the

House of Delegates of the State Association and the House of Delegates of the American Medical Association. Following is the resolution (a copy of which has been sent to members of the family).

"Now and then a man rises among his fellowmen, who like some towering pine among his woodland fellows, throws his shadow farther and makes his presence more deeply felt than most of his fellow workers. And when he passes, the qualities which gave him great stature will shine on long afterwards, even as the setting sun illumines the western sky long after it has disappeared from sight."

"Such a man was the late William Marshall Skipp, M.D., Youngstown, Ohio. His death on March 14, 1956, took from the ranks of the Ohio State Medical Association one of its most influential and best loved members.

"William Marshall Skipp served his profession and its organizations—local, state and national—in many capacities for more than thirty years. After working for his own Mahoning County Medical Society as chairman of each of its important committees, as secretary and as president, he became Councilor of the Sixth District of the Ohio State Medical Association. In due time he became President of the state association and served with distinction. To his credit were many years of service in the House of Delegates of the state association. In the field of national medical organization, he served for fifteen years as one of Ohio's delegates to the American Medical Association and was a delegate at the time of his death. Throughout the years his activity on various local and state committees have been too numerous to mention. However, he was for a long time, one of the most active and effective members of the Committee on Legislation of the state association. At the time of his death he was a member of that committee and was chairman of the American Education Foundation Committee for Ohio.

"In the practice of his specialty—surgery—William Marshall Skipp also displayed unusual skills and abilities. He was recognized as one of his home city's outstanding surgeons. That he was especially talented and experienced in his special field of practice is shown by the fact that he was a diplomate of the American Board of Surgery, fellow of the American College of Surgeons and fellow of the International College of Surgeons, in addition to holding memberships in the Society for the Study of Endocrines and in the American Goiter Association.

"The hold which William Marshall Skipp had on the affections and confidence of his colleagues and his host of friends outside the medical profession was amazing but not difficult to understand. The real key was his disarming frankness and his courage to stand for principle even in the face of stern opposition. His great zeal for fur-

thering the interests of his profession, his generous gift of self to many and varied civic causes, his integrity, his devotion to his family, his loyalty to his friends, and his wise advice when vital decisions had to be made will stand as a lasting monument to a man whose life was dedicated to service. The unrelenting courage which he showed in championing the freedom of medical practice, regarding it as one of the safeguards of our liberty, and the inspirational leadership which he imparted to his associates will continue to be felt now, and in the days to come, even though the scepter has been taken from him.

"Therefore, acting in compliance with official action taken by the House of Delegates of the Ohio State Medical Association in Cleveland, Ohio, on April 12, 1956, expressing sincere grief because of the untimely death of William Marshall Skipp and directing that appropriate resolutions be drafted, we, as a select committee appointed by the President of the Ohio State Medical Association, have prepared and offer this statement in recognition of his untiring efforts and unselfish services and as an expression of sympathy on the part of the medical profession of the State of Ohio. Finally, we recommend that this statement be written into the records of our association and that copies of it be transmitted to the members of the family of William Marshall Skipp, M.D."

Members of the committee which drafted the foregoing resolution were: Dr. C. A. Gustafson, Youngstown, Chairman; Drs. Paul A. Davis, Akron; Carl A. Lincke, Carrollton; and C. C. Sherburne, Columbus.

New Regulations on Licensure of Maternity Hospitals Adopted

July 16 was the effective date for new regulations 71 to 93, inclusive, of the Ohio Sanitary Code, governing the licensure of maternity hospitals.

The new regulations, which have the effect of law, were adopted following a hearing by the Public Health Council of the Ohio Department of Health, June 23, in Columbus. Existing regulations which were first adopted in 1920 and slightly revised in 1943, were repealed. A paragraph had been changed in 1949.

The Ohio State Medical Association was officially represented at the hearing by its president, Dr. Richard L. Meiling. Dr. Meiling presented on behalf of the OSMA Council a number of suggestions for amendment of a proposed draft issued in advance of the hearing by the Public Health Council.

Also present were Dr. A. J. Ruppertsberg, Jr., Columbus, chairman; Dr. John A. Hillabrand, Toledo; and Mr. Hart F. Page, secretary, of the Committee on Maternal Health of the Ohio State Medical Association.

Activities of County Societies . . .

ALLEN

On June 5 the Academy of Medicine of Lima and Allen County met jointly at a staff dinner meeting in Memorial Hospital. The speaker was Dr. Marvin L. Mitchell, chief of endocrinology at Boston's Lamuel Schattuck Hospital.

BELMONT

The final meeting of the season for the Belmont County Medical Society was held with the Auxiliary at the Belmont Hills Country Club. Dr. Charles L. Hudson, Cleveland, Past-President of the Ohio State Medical Association, addressed the group on the subject, "The Doctor and His County Medical Society."

CLINTON

William Dignan, a Cincinnati insurance man, spoke on disability insurance at the June 5 luncheon meeting of the Clinton County Medical Society in the General Denver Hotel, Wilmington.

CUYAHOGA

The following eight persons were elected directors of the Academy of Medicine of Cleveland to serve until May, 1959; Dr. Henry A. Crawford, John J. Grady, Harry A. Haller, John B. Hazard, Harris D. Iler, Chester R. Jablonoski, Clifford J. Vogt and Leo Walzer.

The newly elected directors succeed the following whose terms expired in May: Drs. D. C. Darrah, J. J. Grady, C. L. Hudson, C. R. Jablonoski (re-elected), A. M. Leigh, E. A. Marshall, P. J. Schildt and E. W. Shannon.

Election to the 24-member Board of Directors is on a rotating basis, eight members being elected each year for three-year terms.

President of the Academy for the current year is Dr. A. Macon Leigh. Other officers elected are Dr. Thomas D. Kinney, president-elect, and Dr. Chester R. Jablonoski, vice-president.

FRANKLIN

The Physicians Section of the United Appeals drive was organized and carried on its campaign well in advance of the general United Appeals drive. Dr. Norman O. Rothermich was named head of the Professional Division and Dr. Edwin H. Ellison, chief of the Physicians (M.D.) Section. Numerous other doctors were on committees which took part in the drive.

LICKING

Members of the Licking County Medical Society were guests of the Licking County Pharmaceutical Association on June 7 at the Trout Club in Newark. Speaker was Chauncey D. Leake, Ph.D., assistant dean of the Ohio State University College of Medicine.

MAHONING

About 140 physicians and guests of the Pfizer Laboratories attended the golf meet and dinner in May at the Youngstown Country Club.

MIAMI

Speaker for the June 1 meeting of the Miami County Medical Society was Dr. Robert J. Izanet, of the staff of Children's Hospital in Columbus. His subject was "The Acute Abdomen in Children." The meeting was held in the Dettmer Hospital, Troy, with dinner after the program.

The Society is cooperating in formation and establishment of the Miami County Health Council. Also the Society has purchased an all-purpose slide projector to aid in presentation of programs.

MONTGOMERY

The Montgomery County Medical Society on June 27 chose Dr. A. V. Black, of Centerville, as its president-elect, to assume office in 1958 as the 109th president. The annual meeting was held at Wright-Patterson Air Force Base.

Dr. R. Dean Dooley is the current president-elect and will take office as president the first of January.

Other officers named are Dr. R. S. Graves, vice-president; Dr. D. C. Caudill, secretary; Dr. W. S. Koller, treasurer; Dr. M. S. Jones, trustee for a three-year term; Dr. H. R. Cammerer, delegate, and Dr. L. E. Baker, alternate delegate. Terms of these officers will begin January 1.

SCIOTO

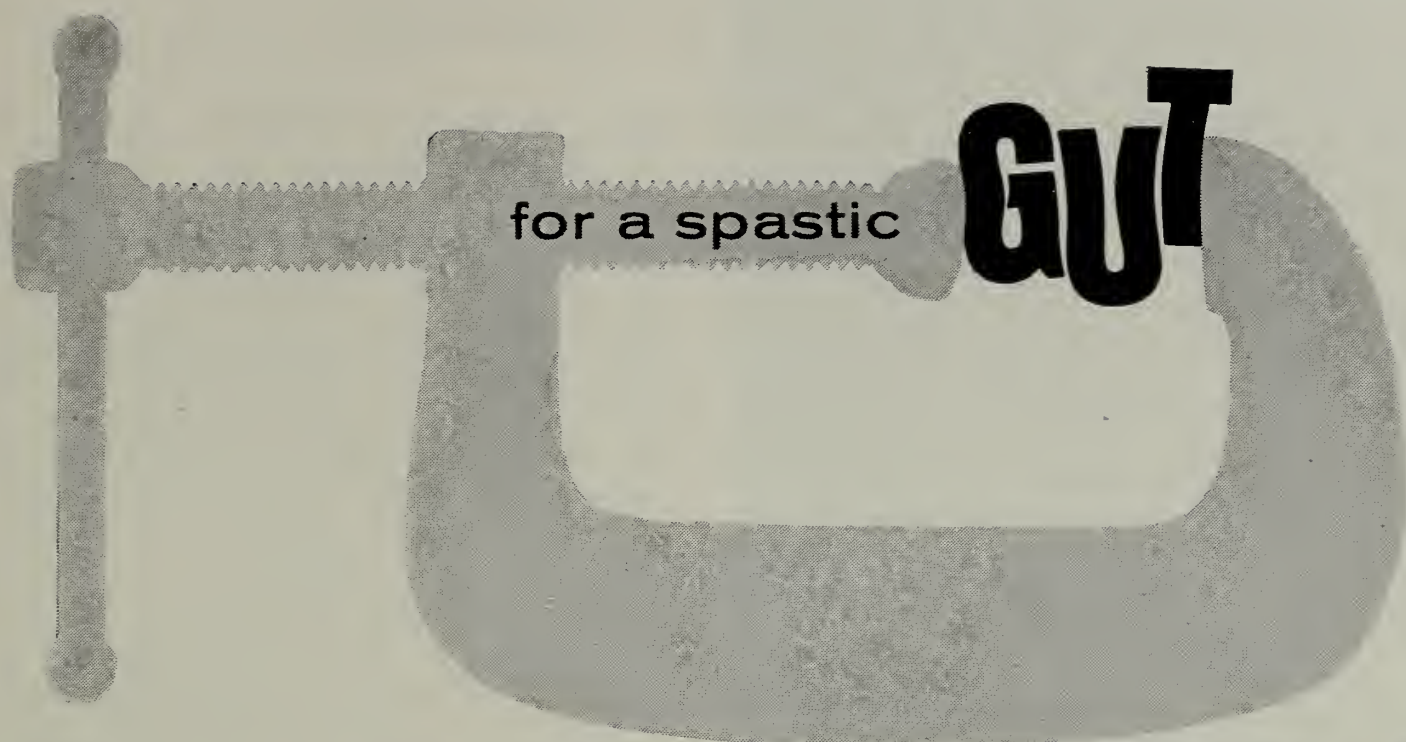
A business meeting of the Scioto County Medical Society was held on July 9 at the General Hospital Nurses Home, in Portsmouth.

Medical Scholarship Fund Established

Major General Carlos Brewer, U. S. Army, retired, and his family, have established the Grace Moore Brewer Memorial Scholarship Fund for medical students at Ohio State University, in memory of his wife. The fund will provide one or more scholarships annually, preference being given to descendants of veterans of World War II or the Korean Conflict who were permanently disabled or lost their lives as a result of service.

General Brewer is associated with the OSU Research Foundation.

Discharge of formerly chronically-ill mental patients, now treated with tranquillizing drugs, increased 36 per cent at the Northampton (Mass.) Veterans Administration Hospital, according to a survey released recently.



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A combined course comprising attendance at clinics and lectures; instruction in examination, diagnosis and treatment; pathology, radiology, anatomy, operative proctology on the cadaver, anesthesiology, witnessing of operations, examination of patients preoperatively and postoperatively in the wards and clinics; attendance at departmental and general conferences.

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c. **OPERATIVE SURGERY** (cadaver). Lectures on applied anatomy and surgical technic of operative procedures. Matriculants perform operative procedures on cadaver under supervision.

d. **REGIONAL ANATOMY** for those interested in preparing for Subspecialty Board Examinations.

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Activities of Woman's Auxiliary . . .

CHAIRMAN, PUBLICITY COMMITTEE—Mrs. Carl F. Goll,
1001 Granard Parkway, Steubenville, Ohio

President—Mrs. William H. Evans, 391 Park Ave., Youngstown

President-Elect—Mrs. V. R. Frederick, 145 Tanglewood Dr.,
Urbana

Vice-President: 1—Mrs. C. H. Bell, Mansfield
2—Mrs. W. R. Gibson, Oak Harbor
3—Mrs. C. A. Colombi, Cleveland

Recording Secretary—Mrs. Lester W. Sontag, Livermore St.,
Yellow Springs

Corresponding Secretary—Mrs. Earl Young, 170 Brookline
Ave., Youngstown

Past-President and Finance Chairman—Mrs. Karl Ritter,
1420 Shawnee Rd., Lima

Chairman Publicity Committee—Mrs. Carl F. Goll

ALLEN

A nurse recruitment tea was held Saturday, April 21, in Lima Memorial Hospital, given by the Auxiliary to Lima and Allen County Academy of Medicine. The guests were girls from the 10th, 11th and 12th grades of Lima and Allen County schools and their mothers.

The Auxiliary committee included Mrs. S. J. Novello, Mrs. Fred P. Berlin, Mrs. R. J. Doernbert, Mrs. V. H. Hay, Mrs. C. L. Steere, Mrs. D. L. Steiner and Mrs. H. L. Stelzer.

May 17 was the date of the second annual Scholarship Fund Ball at the Shawnee Country Club.

ERIE

Something a little different this year! That was the idea behind invitations sent out by the Woman's Auxiliary to the Erie County Medical Society for the traditional annual party. Breaking away from the customary plan of a dinner function, the committee planned a more informal gathering in the Doctor's Reception at Plum Brook Country Club, May 17.

Mrs. Dean Sheldon, chairman, Mrs. W. P. Skirball, Mrs. C. R. Swanbeck and Mrs. C. F. Lavender were the committee "minds" for the affair.

At the outset of the evening, the newly elected officers of the Medical Auxiliary were installed in the one bit of formality. The new slate includes Mrs. W. C. Seiler, president, Mrs. Wm. Skirball, president-elect, Mrs. Paul S. Lafollette, vice-president, Mrs. C. R. Swanbeck, secretary, and Mrs. Herbert F. Kesinger, treasurer.

FAIRFIELD

Mrs. A. B. VanGundy, Mrs. S. C. Sneeringer and Mrs. J. W. Edwards were in charge of arrangements for the final meeting of the Woman's Auxiliary to the Fairfield County Medical Society. It was held on May 8 at the Lancaster Country Club. Final reports were made on the nurse recruitment program, on the convention in Cleveland and the new officers were installed. Mrs. F. W. James, District director, installed Mrs. C. R. Reed as president, Mrs. G. F. Jones, vice-president, Mrs. Geo. LeSar, president-elect, Mrs.

Andrew A. Essman, secretary, and Mrs. J. W. Edwards, treasurer.

GREENE

Thirty-five junior and senior girls of Xenia and Greene County high schools planning to enter nurses' training upon leaving school were guests of the Auxiliary to the Greene County Medical Society at a reception at Greene Memorial Hospital on Sunday afternoon, April 29. The affair is given annually by the Auxiliary to interest young women in the nursing profession.

The final business meeting and election of officers was held on Friday, May 11, in the home of Mrs. Robert Hendrickson. Mrs. Harold R. Tharp is the new president, Mrs. Harry Stoneburner, president-elect; Mrs. Harold E. Ray, secretary; and Mrs. Harvey B. McClellan, treasurer. Mrs. L. W. Sontag of Yellow Springs was elected recording secretary of the state organization, and Mrs. Hendrickson was named to the Nominating committee for 1957. Mrs. Espey was named a delegate to the convention of the Auxiliary to the American Medical Association in Chicago.

HAMILTON

The Woman's Auxiliary to the Hamilton County Medical Society held its final business session at noon on April 24, at the Cincinnati Country Club. Mrs. Henry Clay Beekley was in charge of hospitality for the day, and Mrs. Charles C. Lemert, vice-chairman. Other members of the committee were Mrs. James A. Schaal, Mrs. Albert McErlane, Mrs. John A. Fisher, Mrs. William M. Fischbach, Mrs. Hobart R. Fullerton, Mrs. Harry McFarland, Mrs. John F. Mohan, Mrs. Robert W. Woliung, Mrs. Charles Sebastian and Mrs. Hilmer V. Neumann.

HARDIN

Mrs. Floyd Elliott of Ada was installed as 1956-57 president of the Hardin County Medical Auxiliary when 20 members met in the Guild room at Hardin Memorial Hospital for dinner on May 8.

Mrs. Robert Zeis acted as installing officer. Others assuming their duties with Mrs. Elliott included Mrs. R. A. Dietrich of LaRue, vice-president; Mrs. W. P. Drake of Richwood, secretary; Mrs. W. F. Binkley of Kenton, treasurer.

JEFFERSON

The Jefferson County Auxiliary met in the home of Mrs. Samuel Greenburg for a dessert luncheon on May 4. Mrs. John Mantica was installed as president; Mrs. William Mikita as president-elect; Mrs. Samuel Greenburg as vice-president; Mrs. Jack Cohen as treasurer; Mrs. Donald Myers as recording secretary; and Mrs. D. R. Cahill as corresponding secretary. Mrs. Carl Goll was named State publicity chairman

at the convention in Cleveland. Final committee reports were made, and a party for the doctors was planned for June 16.

KNOX

Mrs. William H. Evans of Youngstown, newly elected state president of the Woman's Auxiliary, was in Mount Vernon April 27 to conduct formal installation of officers of the Knox County Medical Auxiliary at the final business meeting of the current year. New officers are: Mrs. James McLarnan, president; Mrs. O. W. Rapp, president-elect; Mrs. George Imhoff, vice-president; and Mrs. C. E. Cassady, secretary-treasurer. Short talks were given by Mrs. Evans and Mrs. Edward C. Jenkins of Delaware, director of the tenth district.

HURON

Mrs. B. S. Cranston, widow of the late Dr. B. S. Cranston and the mother of Dr. Clyde Cranston of Wakeman, Ohio, opened her early American-style home in New London to the Woman's Auxiliary to the Huron County Medical Society for its May 11 session.

Mrs. Lester Parker of Sandusky installed the following new officers: Mrs. J. D. Bradish, president; Mrs. W. A. Drury, president-elect; Mrs. T. H. Eaton, vice-president; Mrs. D. H. Boals, secretary; and Mrs. Charles Edel, treasurer.

Mrs. Tim. Saunders, Mrs. Robert Harner, Mrs. Arnold Simecek, Mrs. Ned. O'Reilly and Mrs. Robert Krisha assisted Mrs. Cranston with the arrangements.

LUCAS

The Woman's Auxiliary to the Toledo and Lucas County Academy of Medicine was fortunate in having as their guest speaker on April 18, Dr. Glen Rasmussen from the University of Michigan. Dr. Rasmussen's subject was "The Second Sex, Past, Present, Future."

The American Medical Association Education Foundation benefitted from the bridge luncheon which the Auxiliary sponsored on April 24. Mrs. C. S. Kellogg was general chairman, assisted by Mrs. Edward L. Doermann, Mrs. Brian Bradford, Mrs. Henry D. Cook, Mrs. William F. Jeffries, Mrs. William H. Eyster, Jr., Mrs. L. Reed Cranmer, and Mrs. William R. Cather, Mrs. Thomas H. Brown, Jr., and Mrs. W. L. Woodward.

RICHLAND

Mrs. F. M. Wadsworth was installed as president of the Woman's Auxiliary to the Richland County Medical Society following a luncheon on May 7 at the Women's Club.

Other officers installed were as follows: Mrs. Paul Lee, president-elect; Mrs. Harry Wain, vice-president; Mrs. Carl Quick, recording secretary; Mrs. Sigmund Smedal, corresponding secretary; and Mrs. Charles Butner, treasurer. Final reports were made and two new members were

(Continued on Page 884)

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plus positive antacid action
to minimize gastric distress

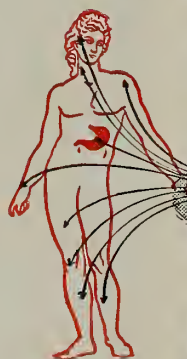
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Clinical evidence^{1,2,3} indicates that to augment the therapeutic advantages of prednisone and prednisolone, antacids should be *routinely* co-administered to minimize gastric distress.

References: 1. Boland, E. W., *J.A.M.A.* 160:613, (February 25,) 1956. 2. Margolis, H. M. *et al*, *J.A.M.A.* 158:454, (June 11,) 1955. 3. Bollet, A. J. *et al*, *J.A.M.A.* 158:459, (June 11,) 1955.

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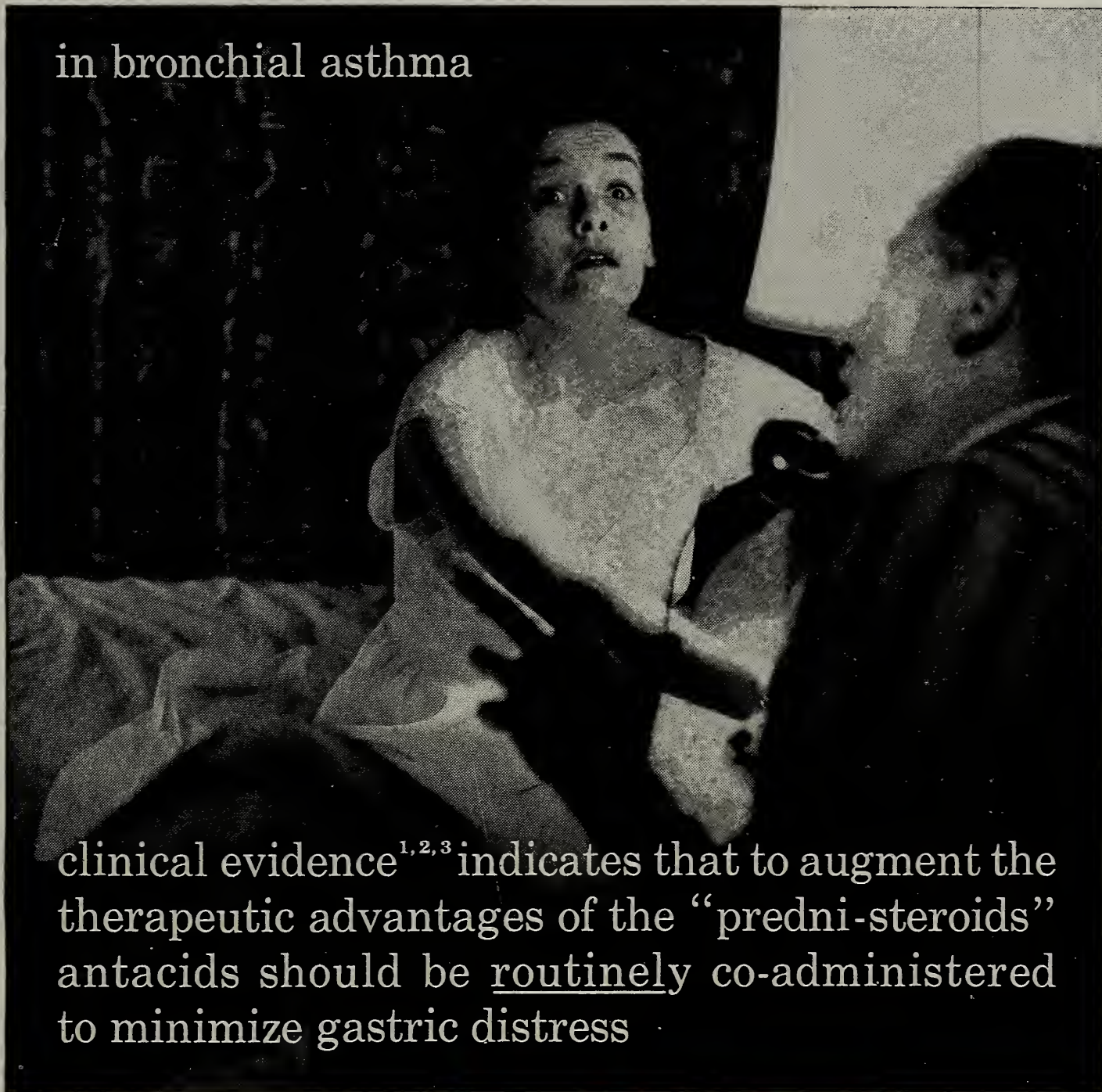
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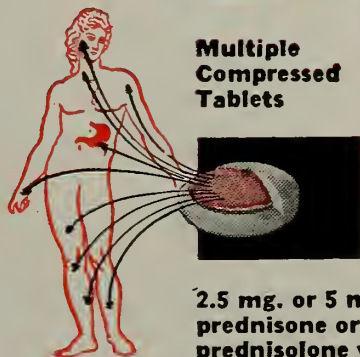
in bronchial asthma



clinical evidence^{1,2,3} indicates that to augment the therapeutic advantages of the "predni-steroids" antacids should be routinely co-administered to minimize gastric distress

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All the benefits of the "predni-steroids" plus positive antacid action to minimize gastric distress.

References: 1. Boland, E. W., *J.A.M.A.* 160:613, (February 25,) 1956. 2. Margolis, H. M. *et al*, *J.A.M.A.* 158:454, (June 11,) 1955. 3. Bollet, A. J. *et al*, *J.A.M.A.* 158:459, (June 11,) 1955.

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introduced: Mrs. Charles Shafer and Mrs. Oscar Klein.

Mrs. C. H. Bell has been elected to serve as first vice-president and Mrs. R. D. Campbell as program chairman of the State Auxiliary.

SCIOTO

New officers of the Woman's Auxiliary to the Scioto County Medical Society were installed at the annual May breakfast at the home of Mrs. H. M. Keil.

Mrs. B. U. Howland, Ninth District director and retiring president of the Auxiliary, installed the new officers as follows: Mrs. C. W. Wendelken, president; Mrs. William C. Hugenberg, president-elect; Mrs. Robert B. Rardin, vice-president; Mrs. Jack MacDonald, secretary; Mrs. W. A. Ray, treasurer; Mrs. Miller F. Toombs, historian; and Mrs. George W. Martin and Mrs. Howland, advisory board members.

SUMMIT

The Woman's Auxiliary to the Summit County Medical Society held its final meeting of the season at Congress Lake Club on May 1.

Mrs. Karl Ritter, of Lima, immediate past-president of the Woman's Auxiliary to the Ohio State Medical Association, installed the following officers for 1956-57: president, Mrs. H. Oliver Musser; president-elect, Mrs. R. R. Pliskin; vice-president, Mrs. R. B. Hosier; treasurer, Mrs. Edwin L. Mollin; recording secretary, Mrs. T. A. Krutky; and corresponding secretary, Mrs. Earl C. Hershberger.

Annual reports were given on Mental Health by Mrs. E. R. Blower; Volunteer service by Mrs. R. B. Hosier; Nurses Revolving Loan Fund by Mrs. J. C. Damitz and *Today's Health* by Mrs. W. M. Keller.

TUSCARAWAS

The annual President's Dinner of the Tucarawas County Medical Auxiliary was held at Bonvechios, Wainwright, on June 14. This event is planned by the retiring officers for the incoming officers taking office in June. The following officers were formally installed by Mrs. H. F. Van Epps, of Dover; Mrs. Ben Pilloff, president; Mrs. Raymond Crawley, president-elect; Mrs. E. L. Miller, secretary, and Mrs. Robert Rinderknecht, treasurer. During the social hour Mr. Ray Forse, of the Uhrichsville Floral Shoppe, gave an interesting discussion on flower arrangements.

Civil Aeronautics Administration, believing the time has come to review procedures in pilot medical examinations, has hired a private organization to conduct a thorough investigation and make recommendations. Two questions: Should lower standards be allowed for older, experienced pilots? Should crew members and ground crewmen, as well as pilots, be examined periodically?

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quence of the salt-free diet
which has occasionally been
known to cause serious
malnutrition."*

*Modell, W.: The Relief of Symptoms, Philadelphia, W. B. Saunders Company, 1955, pp. 265-266.

03156

Ten Ohioans Become Fellows of American College of Chest Physicians

Fellowship certificates were presented to 250 physicians, ten of them from Ohio, at the 22nd Annual Meeting of the American College of Chest Physicians, held in Chicago, June 6-10.

The following physicians from Ohio received Fellowships: Drs. Joseph Aceto, Warren; Robert E. Carr, Youngstown; James J. Conn, Columbus; Robert S. Green, Cincinnati; J. Howard Holmes, Toledo; Harvey J. Mendelsohn, Cleveland; William E. Neville, Cleveland; David K. Scheer, Toledo; Maurice A. Schnitker, Toledo; and Harold H. Tietelbaum, Youngstown.

Dr. Howard S. Van Ordstrand, Cleveland, serves as governor of the College for Ohio.

Ohioans Scheduled on Program of Michigan State Meeting

Several Ohioans are on the program of the Michigan State Medical Society which holds its 91st Annual Session in Detroit, September 26-28. Announced in an early release are Drs. E. Perry McCullagh, Cleveland; Leon Schiff, Cincinnati; Warren E. Wheeler, Columbus; Arthur C. Corcoran, Cleveland.

Physicians from Ohio and other neighboring states have been invited to attend. Wednesday, September 26 is designated General Practice Day.

Additional information may be obtained from the Society at 606 Townsend St., Lansing, Mich.

New Radio Series On Home Safety

Having safe and sane fun in and around the house is the theme of a new series of radio transcriptions the AMA's Bureau of Health Education has produced for use over local radio stations. This "Safe at Home" series features short dramatizations of familiar family situations interspersed with popular musical renditions by the Roger Steele trio.

Titles of the 13 programs are: (1) Care in the Kitchen; (2) Home Check for Fire Hazards; (3) Do It Yourself; (4) Home for the Holidays; (5) Safety in Toys; (6) Pets in the Home; (7) Bedroom and Bath; (8) Sharing Duties; (9) Home Food Care; (10) How to Call a Doctor; (11) Dangers in Home Equipment; (12) Cleaning Materials; and (13) Booby Traps.

Fred V. Hein, Ph. D., educational consultant for the Bureau of Health Education, serves as the health authority.

The chronic rheumatic diseases far outrank every other chronic disease in frequency, affecting more than 10 million adults in the United States. Of those affected, an estimated 1,000,000 persons are disabled for a week or longer each year, 200,000 of whom are virtual invalids, according to the Metropolitan Life Insurance Company.



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Health Department Eases Restrictions Somewhat on Polio Inoculations

With a somewhat larger supply of Salk vaccine coming into Ohio, the Ohio Department of Health has lifted its restrictions to allow second shots to all persons in the 0 to 19 year old group and pregnant women, and first shots to the under-one year age group. The announcement was made by Dr. Ralph E. Dwork late in July after an additional shipment of vaccine boosted the Ohio supply.

Vaccine, supplementing the previously announced supply, was received in the State as follows: June 19—215,892 cc.; June 29—two lots amounting to 348,471 cc.; July 21—309,000 cc.; a total for approximately a month of 873,363 cc. These figures bring the total amount of vaccine received in Ohio since August of 1955 to 3,594,664 cc.

The supply is not unlimited. Dr. Dwork and Dr. Frederick Wentworth, chief of the Division of Communicable Diseases, both stressed the necessity of physicians using discretion in regard to priority in administering inoculations. In any local situation where the potential need is greater than the immediate supply, they urged that priority be given to younger age groups in which the incidence of poliomyelitis is greater. This would particularly apply to the under-one year group who have not as yet received a first shot.

Rules Health Commissioner Must Be Physician Licensed in Ohio

The syllabus of Opinion 6417, recently given by Attorney General C. William O'Neill, reads as follows: "The position of health commissioner of a general health district can be held only by a physician who is licensed to practice in Ohio."

The question was raised as to the language of Section 3709.11 of the Revised Code which states that appointee shall be a "licensed physician." The Attorney General ruled that since the General Assembly inserted the phrase "licensed physician" as a means of setting up certain qualifications, it obviously means a physician licensed under its jurisdiction which would be by the State Medical Board of Ohio.

* * *

Following is the syllabus of an opinion given recently by Attorney General C. William O'Neill:

A hospital which forms a part of a county home maintained and operated by the county commissioners pursuant to Section 337 et seq., Revised Code, is not a county hospital within the meaning of Chapter 339, Revised Code, and such county commissioners have no authority to operate it as a county hospital.—Opinion No. 6274.

The American Academy of Obstetrics and Gynecology has been renamed the American College of Obstetricians and Gynecologists, with headquarters still at 116 South Michigan Avenue, Chicago 3, Illinois.

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- ... a private resident school for children of average or superior intelligence whose psychological difficulties impair their learning abilities and school progress.
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- ... provides a program of education with psychotherapy.
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"...in patients
with moderately
severe and severe
cardiac failure,
neohydrin
is the oral diuretic
of choice."*

*Moyer, J. H., and others:
J. Chronic Dis. 2:670, 1955.

03056

The Importance of Rescinnamine in **Rauwiloid[®]**

The Original Alseroxyton Fraction of India-Grown Rauwolfia Serpentina, Benth.

The isolation of rescinnamine,¹ another potent alkaloid in Rauwolfia serpentina, has substantiated two important points:

A—It discredits the erroneous opinion that reserpine is *the* sole active principle of Rauwolfia;²

B—It helps to define the advantages of Rauwiloid, the alseroxyton fraction of Rauwolfia serpentina, which presents desirable alkaloids³ of the Rauwolfia plant (among them reserpine and rescinnamine) but is freed from undesirable alkaloids and the dross of the crude root.

Pharmacologic and clinical evaluation has shown rescinnamine to be similar to reserpine in antihypertensive activity, but to be considerably less sedative and much less apt to lead to lethargy and mental depression.^{4, 5}

The interaction of reserpine, rescinnamine, and other contained alkaloids may well account for the balanced and desirable clinical behavior of Rauwiloid.

The dosage of Rauwiloid is simple and definite: Merely two 2 mg. tablets at bedtime. For maintenance, one tablet usually suffices.

1. Klohs, M.W.; Draper, M.D., and Keller, F.: Alkaloids of Rauwolfia Serpentina Benth. III. Rescinnamine, a New Hypotensive and Sedative Principle, J. Am. Chem. Soc. 76:2843 (1954).
2. Cronheim, G.; Brown, W.; Cawthorne, J.; Toekes, M.I., and Ungari, J.: Pharmacological Studies with Rescinnamine, a New Alkaloid Isolated from Rauwolfia Serpentina, Proc. Soc. Exper. Biol. & Med. 86:120 (May) 1954.
3. Gourzis, J.T.; Sonnenschein, P.R., and Barnden, R.: Alterations in Cardiovascular Responses of the Dog Following Rauwiloid, an Alkaloidal Extract of Rauwolfia Serpentina, Proc. Soc. Exper. Biol. & Med. 85:463 (Mar.) 1954.
4. Hershberger, R.; Hughes, W., and Dennis, E.: Clinical Results in the Treatment of Hypertension with Rescinnamine, Clin. Res. Proc. 3:71 (Feb.) 1955.
5. Smirk, F.H., and McQueen, E.G.: Comparison of Rescinnamine and Reserpine as Hypertensive Agents, Lancet 2:115 (July 16) 1955.

Riker

LOS ANGELES

Two Ohioans Will Participate in New York Academy Program

Two Ohioans will be on the program of the New York Academy of Medicine 29th Annual Graduate Fortnight, October 15-26.

Dr. Irvine H. Page, Cleveland Clinic, will participate in discussion of the subject, "New Drug Therapy in Psychiatry and Hypertension."

Dr. Albert B. Sabin, Children's Hospital Research Foundation, Cincinnati, will give a lecture on "Poliomyelitis."

"Selected Problems of Current Significance" will be the theme of the series. Additional information may be obtained from the Academy at 2 East 103 Street, New York 29, N. Y.

Friends of the Land 15th Annual Institute Held in Chicago

The Friends of the Land, an organization dedicated to the conservation of soil, water and other natural resources, held its 15th National Nutrition Institute in Chicago, June 25-27. Co-operating in the program was the Committee on Nutrition of the Illinois State Medical Society.

Dr. Jonathan Forman, Columbus, Editor of *The Journal*, and president of Friends of the Land, presided at several sessions and otherwise took a leading role in the program.

Dr. Clarence A. Mills, professor of experimental medicine, at the University of Cincinnati, spoke on the subject, "The Impact of Climate Upon Growth and Maturity and Dietary Requirements." Secretary of the organization is Mr. Ollie E. Fink, Hidden Acres, RFD No. 3, Zanesville.

Huron County Auxiliary Cited

An Ohio County came out tops in its category when honors for chalking up the largest number of subscriptions sales in the *Today's Health* 1955-1956 Woman's Auxiliary contest were announced. The awards were presented during the Woman's Auxiliary convention in Chicago in June.

In the group of county Auxiliaries with membership of 1 to 18, first prize went to the Woman's Auxiliary to the Huron County Medical Society, with Mrs. T. H. Smith, New London, as chairman of the project.

The Council on Undergraduate Medical Education of the American College of Chest Physicians offers three cash awards to be given annually for the best contributions prepared by undergraduate medical students on any phase in the diagnosis and treatment of chest diseases (heart and/or lungs). Additional information may be obtained by writing the College at 112 E. Chestnut St., Chicago 11, Ill.

A two-year clinical investigation by 11 Veterans Administration hospitals revealed that isoniazid (INH) has no beneficial effect on multiple sclerosis, according to a VA report.

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Physicians seeking locations in Ohio are invited to contact the Physicians' Placement Service in the executive offices of the Ohio State Medical Association, 79 E. State St., Columbus 15. Through this medium efforts are made to establish communications between physicians seeking locations and communities where physicians are needed, or other physicians who are in need of associates.

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GENERAL PRACTITIONER with 3 years experience desires Ohio location. Will consider clinic or association with another physician. Ohio license. Write Box 891, c/o Ohio State Medical Journal.

Dr. Sabin Tours Facilities In Soviet Union

By invitation of the Soviet Union minister of health, and with the approval of the U. S. State Department, Dr. Albert B. Sabin, Cincinnati, is scheduled to spend several weeks in the U. S. S. R., where he will tour research facilities and participate in the Congress of Epidemiologists, Virologists, Microbiologists and Hygienists in Leningrad. On the return trip he will visit Copenhagen, Denmark, to appear before the International Congress of Pediatrics.

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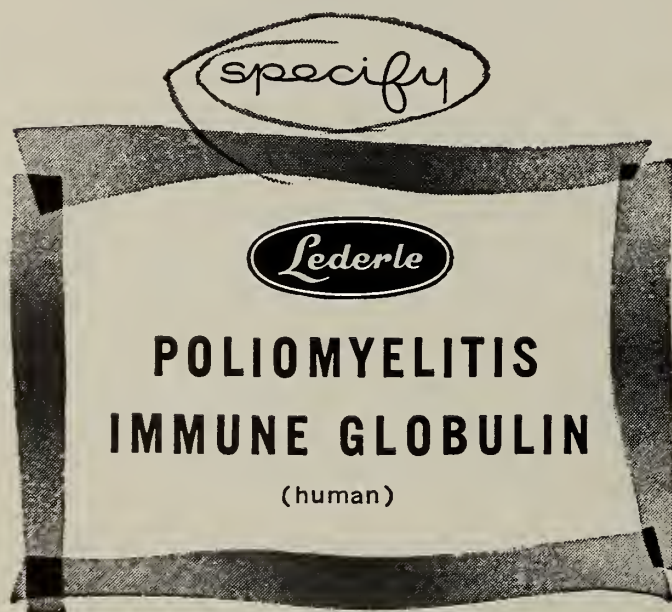
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GYNECOLOGY & OBSTETRICS—Obstetrics & Gynecology, three weeks, Oct. 22. Office & Operative Gynecology, two weeks, Sept. 17. Vaginal Approach to Pelvic Surgery, one week, Sept. 10.

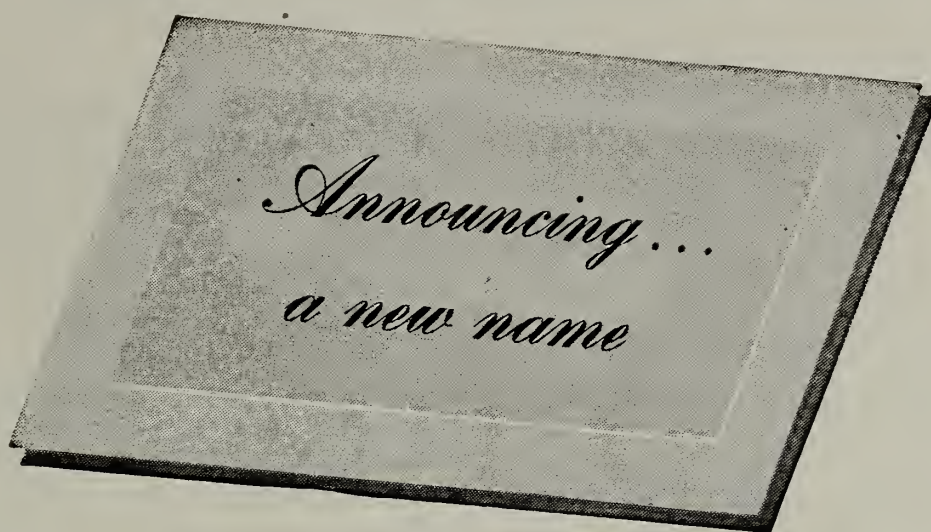
MEDICINE—Electrocardiography & Heart Disease, two week basic course, Oct. 8; one week advanced course, Sept. 17. Internal Medicine, two weeks, Sept. 24. Gastroscopy & Gastroenterology, two weeks, Sept. 10. Gastroenterology, two weeks, Oct. 22. Dermatology, two weeks, Oct. 15. Cardiology (Pediatrics), two weeks, Nov. 5.

RADIOLOGY—Diagnostic X-Ray, two weeks, Sept. 17. Clinical Uses of Radioisotopes, two weeks, Oct. 8.

UROLOGY—Two week course Oct. 8. Cystoscopy, ten days, by appointment.

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The Physician's Bookshelf

By JONATHAN FORMAN, M. D.

Feeding Your Baby and Child, by Benjamin Spock, M. D., and Miriam E. Lowenberg, Ph. D., (\$3.75. *Little, Brown & Company, Boston 6, Massachusetts*). This author's book on common sense in baby feeding and child care is a standard reference in millions of American homes. In this new book, in collaboration with the eminent dietitian and the head of the Department of Foods at Pennsylvania State University, he provides the reader with all the necessary information and basic facts in modern baby and child feeding. For those who know everything about the subject, it is still a thoroughly valuable book to have for those days "when your imagination and your memory fail you."

Kinships of Animals and Man, by Ann H. Morgan, (\$6.75. *McGraw-Hill Book Company, Inc., New York, N. Y.*). This book is a unique textbook on animal biology, treating zoology as a living science dealing with living animals and stressing their ecology.

The Psychoanalytic Study of the Child, Vol. 10 of the Series, by a distinguished editorial Board of the United States and Great Britain. (\$7.50. *International Universities' Press Inc., New York, New York*). This book presents problems of ego-development, genetics, and psycho-physical development, in 19 separate papers by well-known psychiatrists.

Handbook of Medical Library Practice, by Janet Doe and Mary Louise Marshall, (\$10.00. 2nd ed., *American Library Association, 50 E. Huron St., Chicago, Ill.*). The literature of medicine is probably more extensive and more complicated to follow than that of any other discipline. Yet most of us have had no training in the use of the library and if we learn, it has to be in the hard way. This book is intended to make it easier for the medical librarian to serve us in our ignorance and haste.

The bibliography of reference works and histories in medicine and allied sciences is one of the features of great service to the writer as well as his librarian. The main part of the book (336 pages) is devoted to the operation of a medical library and the work of its operators—the librarians.

The Power of Poison, by John Glaister, (\$3.75. *William Morrow & Company, New York 16, New York*). The author, a Professor of Forensic Medicine at Glasgow University, in this book makes a comparative study of the various poisoning cases in recent British history. Here are the techniques, the personalities, the defenses, and the inevitable mistakes that led to detection of such notorious poisoners as Dr. Prichard, Dr. Crippen, Mr. and Mrs. Seddon, and many others.

Diseases of the Ear, Nose, and Throat, by William Wallace Morrison, M. D., (\$10.00, 2nd edition, *Appleton Century Crofts, Inc., New York, New York*). This text is based on 30 years of experience as a teacher of the subject, written entirely for the undergraduate medical student and the general practitioner.

Man's Nature: Nature's Man, by L. R. Dice, Ph. D., (\$5.00. *University of Michigan Press, Ann Arbor, Michigan*). At present the author is Professor of Zoology and Director of the Institute of Human Biology at the University of Michigan. In this book he deals with the ecology of human communities. He tells of the inter-relationship of man in his communities, of his plant and animal associations, and how they act one upon another. He describes the laws that govern our lives, and the mechanism set up by Nature and by man whereby human progress is promoted. He deals with the dynamics of human institutions, and with the biological and moral bases of human communities. Finally he looks upon the prospect before us. A series of well regulated world communities, he concludes, is not likely to be erected soon, or without tremendous effort. Nevertheless, the trend is in that direction.

Suprapubic Prostatectomy, With Primary Closure of the Bladder by a Unique Method, by University Professor D. R. Theodor Hryntschak, translated by Nobel Maluf, M. D., (\$8.50. *Charles C. Thomas, Publisher, Springfield, Ill.*). This gives the preparation, technique, and postoperative treatment. It is intended for surgeons doing operations in this field. It describes the author's method of using the purse-string primary closure of the bladder. Thrombo-embolism is discussed in a separate chapter. There is also a chapter on two-step prostatectomies.

Sex and Repression in Savage Society, by Bronislaw Malinowski, (\$1.25. *The Noonday Press, New York 3, N. Y.*). The author, who from 1927 until his death was Professor of Anthropology at the University of London, has written many books on savage society. "Man is an animal, and as such, at times unclean, and the honest anthropologist has to face this fact. The student's grievance against psychoanalysis is not that it has treated sex openly and with due emphasis, but that it has treated it incorrectly." The author attempts to show that repressions of the physical instincts and some sort of a "complex" must have arisen as a mental by-product of the creation of culture. The author raises important issues which sooner or later have to be considered by the biologist and animal psychologist, as well as by the students of cul-

ture, and when they are considered, most of the arguments will be resolved. This is the first attempt to apply psychoanalytical theory to the study of primitive life.

The Interpretation of Nature and the Psyche: "Synchronicity: an Acausal Connecting Principle" by C. J. Jung; and "The Influence of Archetypal Ideas on the Scientific Theories of Kepler" by W. Pauli, (\$3.00. *A Pantheon Book, 333 Sixth Ave., New York 14, N. Y.*). Volume LI in the Bollingen Series, Jung's publication deals with parapsychology. Pauli (recipient of the Nobel Prize in 1945) describes the conflict between the scientist and the alchemist. He discusses the irreconcilability of scientific and alchemistic methods, in the discrepancy of the symbols used. At the present time there are indications of a reconciliation between what have been opposites in the past, towards a more integrated world view. Proof of this is in this book, which unites the work of a psychologist and a physicist, each eminent in his own field.

Life and Works of Sigmund Freud; Vol. 2, 1901-1919, Years of Maturity, by Ernest Jones, M. D., (\$6.75. *Basic Books, Inc., New York 14, New York*). In this second volume the author tells the story of Freud's life and works from the turn of the century until the end of the first World War, with the active cooperation of the Freud family, and with access to thousands of letters and unpublished records. It depicts Freud in the fullness of his life.

Hypnotic Suggestion: Its Role in Psychoneurotic and Psychosomatic Disorders, by S. J. Van Pelt, President of the British Society of Medical Hypnotists, (\$2.75. *Philosophical Library, New York 16, N. Y.*). Many medical men are interested in hypnotism, chiefly, it would appear, as an answer to the problem of finding a quick method and one which can be generally applied to the psychosomatic disorders of the present day. The author believes that an entirely new approach to hypnotism and the role it plays in the etiology and treatment of these conditions is needed. He has therefore set out his theories and methods in the form of a thesis, to assist those medical men who wish to treat by hypnotic suggestion.

Therapeutic Use of Artificial Radioisotopes, edited by Paul F. Hahn, (\$10.00. *John Wiley and Sons, Inc., New York 16, N. Y.*). An up to date book presenting an authoritative guide to the treatment of virtually all benign and malignant conditions which are susceptible to handling with radioactive isotopes.

Prevention of Disease in Everyday Practice, edited by Isadore Givner, M. D., and Maurice Bruger, M. D., (\$20.00. *C. V. Mosby Co., St. Louis 3, Missouri*). This book has 37 chapters dealing with the preventive aspects of many disorders, accidents, and surgical operations. It has ex-

tended the term "preventive medicine" far into medical practice, so that it is not a book for those interested in Public Health, but is an excellent text for those interested in the health of the public.

Salivary Gland Tumors, by Donald E. Ross, M. D., (\$7.50. *Charles C. Thomas, Publisher, Springfield, Ill.*). After a discussion of the history, the author goes into a very detailed but practical discussion of surgical technique.

Atlas of General Surgery, by Joseph R. Wilder, M. D., (\$13.50. *C. V. Mosby Co., St. Louis 3, Mo.*). Here is a book for surgeons, charting a course to the port of safety for the patient. The author says that it is not necessary for him to show the course of the route so long as he does, with the aid of his charts, reach his objective with safety and a maximum accomplishment for his patient. Typographically it is outstanding, and should be of the greatest usefulness to the rising surgeons of America.

Be Happier and Be Healthier, by Gayelord Hauser, (\$3.00. *Farrar, Straus & Young, Inc., New York 3, N. Y.*). This popular lecturer, who is accused frequently of overstating his case, has successfully attracted the attention and interest of the public, and even when he may not have supporting data for some of his recommendations, still his followers for the most part have profited by them.

How to Live Three Hundred Sixty-Five Days a Year, by John A. Schindler, M. D., (\$3.95. *Prentice Hall, Inc., New York 11, N. Y.*). This best-seller successfully inspires people to meet the six basic needs of man in a way that is satisfactory to them and which contributes somewhat to their longevity.

Special Nurse, by Margaret Howe, (\$2.50. *Bourey & Curl, Inc., New York 22, N. Y.*). This is a story of Forest Lake Hospital, mothered by the widow of a Chicago industrialist who had established the institution. She had brought Richard Harden to the hospital as chief of staff, and he, with his tremendous charm, runs head-on into the chief diagnostician, a rough abrupt fellow, lacking all the social graces which the widow thought the staff needed. Caught squarely in the middle of this situation was Mrs. Hanna's special nurse. Of course, the nurse fell in love with the charming young chief of staff. So we go through severe conflicts and serious operations, and our heroine is saved from drowning by the gruff young doctor, who seems to have been a good man to have around after all.

Textbook of Endocrinology, edited by Robert H. Williams, M. D., (\$13.00. 2nd edition. *W. B. Saunders Co., Philadelphia 5, Pa.*). There are 10 contributors to this book, including Dr. Harry B. Friedgood of Toledo, Ohio. It incorporates the

most recent advances which compelled the re-writing of a large portion of the book from its 1950 edition. There is much new information concerning thyroid, cortisone, and ACTH, as well as testosterone and other hormones.

An Atlas of Clinical Pathology of the Oral Mucous Membrane, by Balint Orban, M. D., Frank M. Wentz, Ph. D., and a score of contributors. (\$12.50. *C. V. Mosby Co., St. Louis 3, Mo.*). This book presents the subject in 72 colored illustrations, 142 in black and white, and 14 charts.

How to Help the Baby Grow, by Julia M. Long, (\$1.50, paper cover. *Greenberg Publisher, Inc., New York 22, N. Y.*). Here is a simplified guide for parents and baby sitters. It contains common-sense information on the care of the child up to his fifth birthday, emphasizing the necessity of the child's feeling that he is wanted and that he is secure.

An Elementary Textbook of Psychoanalysis, by Charles Brenner, M. D., (\$4.00. *International Universities' Press, New York, N. Y.*). This book intends to provide a clear and comprehensive exposition of the fundamentals of the psychoanalytical theory. It does not demand any previous psychoanalytical knowledge from the reader, and should serve him as an introduction to the literature on the subject.

Four Children for the Doctor, by Evelyn Barkins, (\$3.00. *Frederick Fell, Inc., New York, New York*). Most of our readers will remember the author's previous books: **The Doctor Has a Baby**; **The Doctor Has a Family**; **Are These Our Doctors?** This is the story of the husband and father, a practicing physician, and of his loyal wife and the children, Lizzie, Martha, George and Bradley. Mrs. Barkins's books are well remembered for their humor. Her last volume raised questions of medical ethics and was irritating to many because it seemed to imply that a large percentage of medical practitioners are inept. Here in this book is the story of what happens in the modern home when the author and the already emancipated children try to take over the blessed event, and try to turn it into their own pet project. The startled parents suddenly make the discovery that their marriage is a full-scale family project, complete with junior partners. Somehow I have the feeling that this is not quite up to the standard of the previous volumes.

Sex and Marriage, by Dr. Allan Fromme, (\$1.50. *Barnes and Noble, Inc., New York 3, N. Y.*). This book has previously appeared under the title **The Psychologist Looks at Sex and Marriage**. It has been designed as a guide to better marriage. Its goal is to improve the quality of our thinking about the subject and about ourselves. The author deftly presents a sound psychological interpretation of what emotional maturity means and how it can be achieved, and how

maturity can be utilized in courtship and marriage to make a successful issue.

Sociology and Social Problems in Nursing, by Sister Mary Isidore Lennon, (\$4.75. 2nd edition, *C. V. Mosby Co., St. Louis 3, Mo.*). In this second edition of a well-known work, the text has been broadened to include certain elements basic to comprehensive nursing. They embrace not only the physical well-being of the patient, but also such dynamic factors as the age of the patient, the nature of his illness, his family constellation, his economic status, his religion, his responsibilities, his intelligence, and his total personality.

An Introduction to Human Anatomy, by Clyde Marshall, M. D., Revised by Edgar L. Lazier, Ph. D., (\$4.50. *W. B. Saunders Co., Philadelphia 5, Pa.*), with 32 illustrations, 15 in color. While the original plan has been followed and its purpose adhered to, some studies have been re-arranged in conformity with the principle that some understanding of the materials of which an organ system is built is a necessary preliminary to any study of that system.

The Diabetic's Cook Book, by Clarice B. Strachan, (\$6.50. *The University of Texas Press, Austin 12, Texas*). This book contains over 200 recipes for the preparation of beverages, pastries, desserts, fruits, meats, salads, sandwiches, and vegetables which fit into the dietary program of the diabetic. It shows total amounts of proteins, carbohydrates, and fats, as well as the caloric value of each serving. Everything in one book, to aid the diabetic to prepare foods which fit properly into his diet.

The Practical Nurse and Her Patient, by Fern A. Goulding, R. N., M. S., and Hilda Torrop, R. N., B. S., (\$4.25. *J. B. Lippincott & Co., Philadelphia 5, Pa.*). This is a practical, illustrated guide designed to help the person who is caring for the sick to do a competent job. Whether the patient is at home or hospitalized, this book provides the precise knowledge, the self-confidence, and the information for the efficiency which the case demands.

Nutrition and the Diet in Allergy, by Clarence S. Bucher, M. D., (\$7.50. *Educational Publishers Inc., St. Louis 1, Mo.*). This is a comprehensive coverage of the nutritional and dietetic problems of food sensitive individuals. It aims to assist in the selection and preparation of foods for allergic patients of all ages. It is designed as a guide in acquiring and maintaining optimal nutrition. It also contains suggestions for substitutions of foods, palatable recipes and menus to permit the entire household to be on the same diet essential to the allergic child, and thus to prevent the mental stigma which too frequently occurs when a child is served dishes which the remainder of the family do not, and probably would not, touch.

The Ohio State Medical Journal

Published under the direction of The Council for and by the members of The Ohio State Medical Association, a scientific society, non-profit organization, with a definite membership, for scientific and educational purposes.

Vol. 52

September, 1956

No. 9

JONATHAN FORMAN, M. D., *Editor*

CHARLES S. NELSON,
Managing Editor—Bus. Mgr.

R. GORDON MOORE,
Asst. Managing Editor

Prevention of Deformity in Poliomyelitis

NADENE COYNE, M.D.

WITH the recent advent of vaccine for poliomyelitis there is an increasing expectation that soon this will be a disease of the past. As this expectation increases, the terrible seasonal apprehension decreases. However, if there were no new cases of poliomyelitis from this day on, there would still be thousands of cases needing care for many years to come. Most of this care would be directed toward the prevention or correction of deformity.

Unlike smallpox and other diseases that have been relegated to a few paragraphs in a textbook by vaccination, the recovery or convalescent period for poliomyelitis is calculated in months and years. A minor deformity in a child, unwatched, becomes a major deformity or series of deformities as he grows. A potential deformity in a thin adult becomes a real deformity in an obese adult.

Any physician who accepts the responsibility for the care of the poliomyelitis patient should be aware of the following facts:

1. Prevention is possible and the only satisfactory method of treatment.
2. Deformities develop slowly without warning signals—no pain, fever, or swelling herald their onset.
3. A deformity rarely exists alone; unless adequate measures are taken, one will lead to another in a relentless chain.
4. Motion may be just as deforming as lack of motion.
5. Even a mild deformity limits the functional recovery of the patient.

The Author

● Dr. Coyne, Cleveland, is director, Department of Physical Medicine and Rehabilitation, City Hospital; assistant professor, Department of Medicine, Western Reserve University School of Medicine.

6. Deformities can rarely be corrected by conservative means, and not always by surgery.

The musculoskeletal system of the human body is made up of bones joined together and supported by soft tissue—mainly muscle. In general, the mechanics of motion are those of the lever and the pulley. Motion of joints is controlled by a balance of muscle power around the joint. Motion in any one joint requires stabilizing muscle power in the joints above and below. No one muscle ever acts alone. Weight bearing, whether sitting or standing, greatly increases the number of muscles that must come into play to keep the body erect and maintain the center of gravity over the base of support.

In general, when considering the etiology of deformity, it can be summed up very briefly—persistent faulty position. Many factors may contribute to faulty position, but two are primary—unsupported weakness, and imbalance in muscle strength.

EARLY CARE

In the acute stage of the disease, pain and muscle spasm are the symptoms that are most likely to contribute to deformity. The aim of treatment at this time is to save life and to

Presented before the Section on Physical Medicine, April 11, 1956, at the Annual Meeting of the Ohio State Medical Association in Cleveland.

make the patient comfortable without contributing to possible future deformity. The evaluation of the muscle status during this febrile stage should be as brief as possible. A detailed muscle examination is unnecessary; it is sufficient if gross body segments are recorded as normal, weak, or paralyzed. Repeated testing exhausts the patient and may well increase the amount of his residual weakness or paralysis as it is known that increased activity during this phase results in more severe residual damage.

The bed position should be as near normal as comfort allows; no pillow should be used, for it merely increases the tension on tight and painful posterior neck and back muscles.

HAND AND FOOT SUPPORT

Deformities of the hands and feet develop rapidly. If weakness is present, preventive measures should start as soon as the patient is hospitalized. Foot supports and knee rolls to hold the knee in slight flexion are fairly standard equipment wherever acute polio is treated. They are of value only if the person in charge of positioning the patient understands their correct usage. The knee roll should be just enough to relieve tension on tight and painful hamstrings and gastrocnemius-soleus muscles; a pillow under the knees lays the foundation for tightness of the ilio-tibial bands, hip flexors and hamstrings.

The type of foot support should be carefully chosen. If the muscles of the entire lower leg are paralyzed, the foot will dangle into a position of plantar flexion. If allowed to persist, the plantar structures will tighten. Any type of simple foot board or drop foot splint that holds the foot up, is usually sufficient. Low-heeled, oxford type shoes should be put on early to protect the anatomical relationship of the midfoot and forefoot. If the foot is held in plantar flexion by spasms of the calf muscles, it may be necessary to allow slight plantar flexion in the foot support at the onset, then gradually bring it up to a right angle as pain and spasm are relieved. If this equinus position is allowed to persist, careless stretching of the heel cord or weight bearing at a later date will lead to hyperextension of the knee.

In the presence of weakness of the gastrocnemius-soleus muscles, one type of foot board is dangerous. That is the so-called trough type, or the foot board that is separated from the end of the mattress by several inches. The heel is jammed down between the mattress and foot board, or into the trough; the paralyzed muscle is stretched, heel cord elongated, the os calcis rotates from a fairly horizontal to a more vertical position, and the plantar fascia tightens. You now have a calcaneus deformity and are well on your way to a cavus foot. The possibilities of this deformity are greatly enhanced if the dorsiflexors of the foot and plantar flexors of the

toes remain intact. Shoes should be applied early, with a simple foot board.

With children, high-top tennis shoes with a horizontal anti-rotator bar attached to the base of the heels is often sufficient to support both the foot and the tendency for external rotation of the leg. In addition to foot support adults will need a sandbag or similar support at the outer side of the knee to counteract this tendency.

The most frequently involved muscles of the hand are the intrinsic muscles of the thumb and index finger. The importance of these tiny muscles can only be realized if you consider that the ability to lift the thumb up from the palm of the hand and oppose it to the finger is classified as 50 per cent of the function of the entire hand. Weakness or paralysis of these muscles allows the thumb to fall back in line with the fingers and lie close to the index finger. If this position is not corrected early, the soft tissues of the web space between the thumb and index finger will tighten and even if the neurons controlling these muscles recover at a later date, the function will be lost. Where tendon transfers might have restored function, they would be of no value if the web space is gone.

The first dorsal interosseus muscle to the index finger is the main finger muscle involved in pinch. Early in the course of treatment, the hand should be supported by soft rolls so that there is slight extension of the wrist, slight flexion of all the joints of the fingers, and straight abduction of the thumb. Later, hand splints can be made to support specific weaknesses in the hand and wrist and preserve the web space of the thumb.

POSTFEBRILE CARE

In the postfebrile stage, hot packs and gentle stretching will provide relief of most of the pain and tightness. Motion then becomes the most important thing to the patient. If not carefully evaluated and instructed, the patient with muscle imbalance will rapidly develop abnormal patterns of motion by substituting unaffected or slightly weak muscles for paralyzed or severely weakened muscles. Once these patterns are established they may be difficult or impossible to break even with the most skilled muscle re-education and forceful bracing of the entire part. Functional motion should only be permitted if it results in coordinated movement. After a sufficient period has elapsed for neuro-anatomical return of function, and an adequate period of muscle re-education has been tried, then only, is substitution of muscle function encouraged.

All too often, remaining muscle strength is of no functional value but may act as a severe deforming factor if unopposed by an antagonistic muscle of approximately equal strength. For example, unopposed peroneal muscles will result in a valgus deformity of the foot which is increased by weight-bearing. This must be care-

fully explained to the patient, so that he is not constantly contracting an unopposed muscle. Unfortunately, well meaning people too often encourage the poliomyelitis patient to move anything that he can.

SELECTED STRETCHING

Stretching of tightness must also be approached with care and judgement. As a general rule, treatment is aimed at retention of or return to a full normal range of all joint motion. But each patient must be evaluated individually. In some areas tightness may be protective rather than limiting.

Where no active motion is present in the shoulder girdle, the stretching of tightness should be limited to that range that will be necessary for the normal activities of daily living, such as dressing and eating. In the shoulder, this is usually a range of 90° of flexion and abduction, and 45° of internal and of external rotation. Stretching out a flail shoulder girdle to its full range of motion will only result in an eventual subluxated and painful shoulder. Another area where this type of "protective tightness" may be allowed to remain is in the symmetrical tightness of a very weak back. Unilateral tightness must be stretched out or it will be a contributing factor in the development of scoliosis. Some tightness left in the hamstrings and gluteus maximus will often help to counteract the lordotic tendency in a patient with very weak abdominal muscles and strong lumbar back extensors.

On the other hand, one area must be stretched regularly long before there is any indication that tightness is developing—the iliotibial band. This band with its allied structures is probably the greatest deforming factor where there is involvement of the trunk and lower extremity. In children, it may be impossible to prevent some degree of deformity even with the best care. With its extensive origin and attachments, spanning both the hip and knee joints, progressive tightness of one band can result in a chain of deformities from the foot to the occiput. Once tightness has developed, no conservative measures will be corrective.

As the band lies anterior to the hip joint and posterior to the knee joint, the chain usually starts with flexion and abduction contractures of the hip, continues with external rotation of the hip, genu valgum, knee-flexion contracture and external tibial torsion. If the patient is then braced without consideration for the external rotation of the hip and the external tibial torsion, the foot will be forced into a position of varus. This functional varus becomes a structural deformity if allowed to continue over a period of time. If this patient is allowed to sit or stand, the necessity of having the legs together in adduction forces the pelvis down on the side of the tightness into an oblique position. This is equalized by a lumbosacral scoliosis. If both

bands are tight, the compensation in the back results in an exaggerated lumbar lordosis.

SCOLIOSIS

Scoliosis is a topic in itself, so only a few specific points will be touched upon. This deformity may develop very rapidly, or insidiously over a period of years. A number of factors must be taken into consideration in planning a program to prevent scoliosis in the poliomyelitis patient. In the patient with symmetrical weakness of the back or abdominal muscles, unrestricted sitting or insufficient support start the process on its way. The patient will slump and asymmetrical soft tissue tightness develop—structural changes follow.

Gravity is not necessary, however, for the development of scoliosis; asymmetrical weakness of the muscles of the neck, shoulder girdles, back, abdomen or hips can lay the foundation for scoliosis in a patient at bed rest. Physical measures can prevent or minimize the development of significant curves only if all the causative and accelerating factors are recognized and corrected before irreversible changes take place. The maintenance of symmetrical mobility, adequate supportive apparatus, and restriction of activity must be continued for years in the growing child.

CONVALESCENT PERIOD

During the convalescent period, increase in activity should be permitted as rapidly as it is safe for the patient. For maximum recovery, a careful balance of rest and activity is essential. The convalescent poliomyelitis patient fatigues rapidly, but will recover rapidly if he rests at the first sign of fatigue. However, if the patient continues activity beyond the point of beginning fatigue he will slip into poor patterns of motion and find his recovery time greatly prolonged.

Supportive apparatus, even if used only temporarily, must fit the patient. A patient cannot be fitted into a brace. Deformities cannot be corrected by static bracing. Deformities must be corrected first. Dynamic bracing will help to correct contractures of soft tissue, particularly around non-weight-bearing joints.

RESPIRATORY INVOLVEMENT

The patients with respiratory involvement present special problems. They are usually highest on the list of total muscle involvement. During the course of their care they may require a team of physicians with special medical skill from the oral surgeon to the urologist, for the complications possible in this one disease. Every conceivable musculoskeletal deformity is possible. Any of these patients who has spent more than a few weeks in an iron lung will have some degree of tightness in the shoulders. The intercostals, back and/or abdominal muscles are invariably affected, muscles of the neck and shoulder girdles in the majority of cases.

Neither the iron lung nor the chest respirator

prevents tightness developing in the rib cage where intercostal muscles are paralyzed. A tight rib cage may limit the ultimate vital capacity of the patient. Physical measures to retain or regain mobility of the rib cage by stretching should be supplemented by short periods of forced positive pressure and by teaching the patient glossopharyngeal breathing, if possible. All physical and occupational therapy, and gradation of activity must be based primarily on the respiratory status. Because of rapid fatigue, many short periods of therapy are preferable to one or two longer periods.

Unfortunately, in the past, a tremendous emphasis has been placed on weaning the patient from all respiratory aid as quickly as possible. This results in a patient able to maintain himself, at a basal level, without respiratory aid, but without sufficient respiratory reserve to do any type of activity. Personnel in respirator centers have found that the patient's general health, respiratory status, and functional ability have improved more quickly if the freedom from respiratory aid is de-emphasized and a functional goal substituted. This does not result in dependency on artificial respiratory aid. For instance, we find no difficulty in persuading patients to sleep with respiratory aid, if they see that they can sustain more activity the following day.

Some type of trunk support is necessary for most of these patients when they are out of the lung or chest respirator. Here again the pattern of weakness and type of respiration must be taken into consideration. A corset is almost a necessity if abdominal muscles and/or diaphragm are paralyzed, but should not impede intercostal motion. A patient who breathes with the anterior neck muscles but whose posterior neck muscles are weak will need some type of neck support in the sitting position; but this support cannot be rigid. The patient must have enough support to initiate neck flexion and still supply stability so that the motion will be transmitted to the chest and not merely pull the neck down. These are but a few of the factors that must be considered in the severe poliomyelitis patient. All types of adaptive equipment are usually necessary to permit these patients to be as functional as their residual weakness allows and to relieve other members of the family from constant attendance on the patient.

Lastly, because I consider it the most important, the patient, the nurse, therapists, husband, wife or parents must understand why preventive measures are necessary and why they must be done daily. When a deformity is obvious, it is easy to convey the idea that something should be done about it. Prevention must be "sold" ahead of time, and a careful follow-up program instituted over a long period of time, to insure results.

Therapeutic Measures for Severe Chronic Pruritus Vulvae

If the frequency in numbers of treatments for a single condition were recorded, at the head of the list would be vulvovaginitis. . . . In at least 80 per cent of the patients the disease has its origin in *Candida albicans* (monilia), or *trichomonas* vaginitis, with a scattering of allergies, leukoplakia, atrophic vulvitis, condylomata acuminata, herpes, and chemical dermatitis.

The interesting features seem to be that any patient who has this disorder longer than six months or a year has an accomplished fixation in that area. The separate manifestations and descriptions by the patient depend on her own pattern of reactivity. Any protracted instance may come from overtreatment, real or supposed guilt on the part of the patient, unexpressed hostility and resentment, or obvious disgust and disinterest on the part of the physician.

The therapeutic measures for so-called "leukorrhea" are actually few. When it is associated with pruritus, they should be concerned principally with *trichomonas* or monilia. Merely differentiating these two may solve the problem on the initial visit. *Trichomonas*, or the anaerobes associated with it, produces typically a foul, yellowish, watery and slightly foamy discharge. It is exaggerated around the time of menses, and maintaining an acid medium will usually suppress it.

It is necessary for the patient to take douches while she is menstruating. Otherwise, the change in hydrogen ion concentration that occurs toward the alkaline side during menses will allow a return of the symptoms. If douches with lactic or acetic acid are taken, they should be cool. Heat seems to produce relief in some patients, but is followed by a rebound phenomenon of intense itching.

Monilia on the other hand has its onset in the middle of the cycle, is characterized by heavy white discharge, most of which remains in the vagina and is not apparent to the patient. The principal symptoms will be external or vulvar rather than internal.

It is no longer necessary to use gentian violet; the newer creams containing sodium acid propionate are preferred. The patient is instructed to take a plain cold water douche and then begin twice daily intravaginal applications of the cream with an inserter. . . .

Emphasis must be placed on the treatment of patients with severe chronic vulvitis. I am convinced that hormones are of no assistance either as suppository or cream. Roentgen therapy is definitely damaging to the tissue and the circulation, despite the fact that it will temporarily relieve the itching. It seems impossible to handle these patients without employing the psychogenic approach.—Robert N. Creadick, M. D., Durham, N. C.: *J. Florida M. A.*, 42:1007, June, 1956.

Liver Function Studies in a Case of Massive Rupture Of the Liver

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AN unusual opportunity to obtain some liver function studies in massive rupture of the liver presented itself when such a case was admitted to our hospital.

Most of the laboratory studies accomplished were, we felt, required to keep abreast with the patient's physiologic status and to meet the complications as they were recognized. It is not possible to determine which of the changes in the laboratory studies were due to the extensive liver trauma, which were due to infection, or which to loss of body fluids. No comparable study is found in the literature.

It is impossible to draw any conclusions from this single study.

CASE REPORT

The patient, Mr. _____, age 25, was admitted to the hospital January 19, 1951, following an accident in which he was struck in the abdomen by a swinging 5,000 pound crane-operated electromagnet which had pinned him against a truck. He complained of pain in his abdomen, right shoulder, and right flank. The examination of the chest showed equal but markedly limited expansion due to pain on inspiration. All of the breathing was thoracic. The abdomen was rigid. There was apparent fullness of the right flank and the right side of the abdomen. This region was markedly tender, with rebound tenderness referred to the right shoulder.

Because of the grossly bloody urine, the patient was taken to surgery but detoured through the department of radiology where an intravenous pyelogram showed normal functioning kidneys. He was operated upon within two hours after surgical consultation.

The abdomen was opened through the right pararectus incision and an explosive rupture of the liver was found. It involved the entire right lobe of the liver, measuring approximately 27 centimeters. Five pieces of liver were found free in the subdiaphragmatic space. The depth of the lacerations was greater than the length of the surgeon's fingers.

Attempts to use hemostatic agents such as gelfoam® failed to control bleeding, as did suturing; therefore two abdominal packs were used to control the bleeding, and the abdomen was closed with the packs being brought out through a stab wound. His blood pressure varied before the operation from 108 systolic and 56 diastolic to 88 systolic and 36 diastolic. He received whole blood and fluids before being operated upon.

The patient received adequate supportive therapy and on the fourth postoperative day he began to show evidence of fluid in his right chest. A thoracentesis revealed 250 cc. of bloody fluid and 850 cc. the next day.

On the sixth postoperative day the packs were removed through the original incision and Penrose drains were inserted. That night the patient broke three of the five steel sutures used

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to close the wound. He did not, however, eviscerate. The next day he broke another steel suture but the one remaining suture seemed adequate to prevent evisceration.

The next complication was noted on the ninth postoperative day, when he became disoriented and distended despite normal bowel movements; and a potassium deficiency, due to inadequate intake, gastric suction and large amounts of intravenous fluids, appeared. He responded remarkably well to potassium therapy.

His temperature started down from approximately 103°F. on the eleventh postoperative day but spiked to 106° on the fifteenth day and 107° on the eighteenth day. Then it settled down to a level of approximately 100°. On the eleventh postoperative day, before the temperature spiked, two abdominal abscesses were drained and the culture showed a *Staphylococcus aureus*. The abdominal drains were removed on the sixteenth day because of the high temperature and the inadequate drainage.

Two modified catheters were inserted into the wound and suction was applied through one of these catheters and the temperature improved. The abdominal wound itself responded well to nitrofurazone* locally.

The pulse was elevated out of proportion to the temperature on the twenty-second day. The serous drainage from the abdomen became bloody and showed a 2 per cent hemoglobin. He continued to bleed for 12 hours following a puncture wound for a blood count. The spleen was found to be markedly enlarged and the platelet count was 60,000, probably due to a toxic splenomegaly with a thrombocytopenia. He went into shock which took approximately five and a half hours before the blood pressure was stabilized. He was started on 25 mg. of ACTH every six hours for 24 hours. He went into shock again the following night and it was found that he had developed an acute gastric dilatation and retention. He

responded to treatment of suction and other supportive measures after five hours.

Fifteen milligrams of ACTH every six hours was given for three days and 10 mg. every six hours for two days. Bleeding had stopped promptly and by the fifteenth postoperative day the platelet count was 311,000 per cubic millimeter. Daily taps of the chest showed that the fluid contained bile. It changed to a purulent material, and on the thirty-third day after his original operation a hemolytic *Staphylococcus aureus* was isolated. By sensitivity tests it was found to be resistant to penicillin, streptomycin, bacitracin, chloromycetin,® and moderately resistant to terramycin.® A catheter was placed in the superior and inferior portions of the pulmonary abscess and a constant drip and tidal irrigation was instituted with terramycin® and later bacitracin. The abscess responded slowly and closed.

On the thirty-fifth day the patient developed a thrombophlebitis in both legs and was treated with elastic bandages and ambulation to which he responded well. He had been ambulatory on and off since the first postoperative day. His temperature was normal on the thirty-sixth postoperative day.

The patient weighed 175 pounds before his injury and by the thirty-third day after the injury he had lost 50 pounds. By the seventy-eighth day postoperative he had gained back 15 pounds.

On April 16, 1951, the eighty-seventh postoperative day, he developed an intestinal obstruction and a thrombosis of a major omental vessel. He was successfully operated upon and a large section of the omentum was excised and the obstruction was relieved by dividing the adhesive band. He was discharged from the hospital on the 106th day after the original operation with drainage tubes in the abdominal wound. These tubes were gradually forced out and the wound was closed by the second week after discharge. At this writing the patient is back at work at his former job and has regained all of his weight loss.

LABORATORY DATA

The following blood chemistry studies were determined throughout the hospital course and after complete recovery: serum cholesterol, thymol turbidity, cephalin flocculation, prothrombin time, serum bilirubin, total protein, albumin-globulin ratio, the copper sulfate method for fluid balance, carbon dioxide combining power, sodium and chloride determinations, and non-protein nitrogen. The very first postoperative day the blood chemistry showed a normal cholesterol of 135 mg. per 100 cc. with cholesterol esters 114 per cent. The cephalin flocculation was 3 plus and prothrombin time 40 per cent of normal. The serum bilirubin determination was normal.

It can be seen (table 1 and figure 1) that the prothrombin time throughout his hospital course was abnormally low or at low limits of normal, in spite of numerous transfusions and Vitamin K. The most profound changes were in the cholesterol studies (table 1, figure 2). It fell from normal to 81 mg. per 100 cc. on February 1. It then slowly rose to a normal level by April 12. Esterification was normal all during this time.

Interesting changes were noted in the albumin-globulin ratio (table 2 and figure 3). Whereas

the total proteins were normal, the albumin-globulin ratio was constantly abnormal, varying from 0.4:1.0 to a high of 0.9:1.0 and returned to normal after five months. The patient at no time showed evidence of edema.

The bilirubin (table 3) showed slightly abnor-

TABLE 1

Date	Cholesterol mg./100 cc.	Cholesterol Esters mg.	%	Prothrombin % of Normal
1/20/51	135	114	84	40
1/23/51	---	---	---	60
1/29/51	93	63	70	---
2/ 1/51	81	61	76	40
2/ 5/51	88	75	85	42
2/ 9/51	116	71	62	---
2/10/51	---	---	---	34
2/15/51	122	93	75	60
2/21/51	135	89	66	---
2/27/51	135	110	85	70
3/ 7/51	135	109	84	38
3/ 9/51	---	---	---	50
3/17/51	130	110	89	70
3/26/51	---	---	---	70
4/12/51	157	145	91	80
5/24/51	164	126	80	80
6/ 4/51	157	82	52	80
2/26/52	168	121	72	100

Prothrombin Time

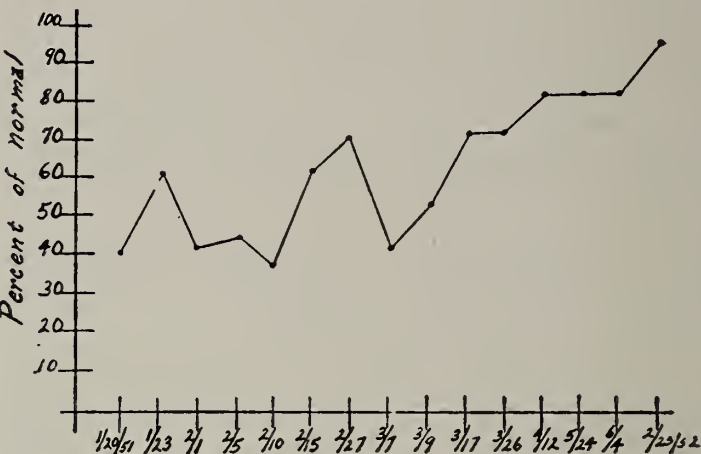


Fig. 1.—Note fall of prothrombin time to 34 per cent of normal and gradual rise to 100 per cent of normal in 12 months.

Cholesterol and Esters

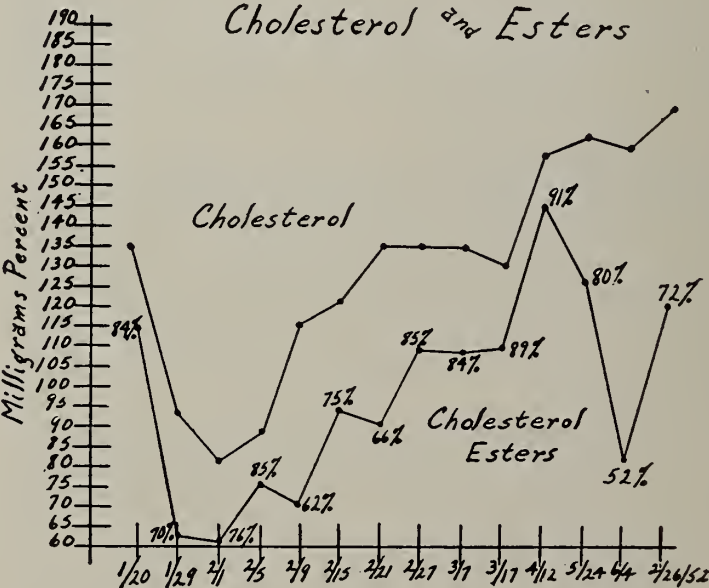


Fig. 2.—Note cholesterol and cholesterol ester level on date of injury (1/20/51), gradual fall to a low total cholesterol of 81 mg. per 100 cc. with a normal per cent esters and a gradual return to normal levels in one month. Unexplained is the 52 per cent esters on June 4, 1951.

mal changes up to 1.55 mg. per 100 cc., apparently due to increased indirect bilirubin fraction. His cephalin flocculation tests were almost constantly abnormal, showing 3 plus, falling to 2 plus.

Electrolyte studies were normal except for one potassium determination which showed 24 mg. per 100 cc. on February 13.

It can also be seen that there was a mild to moderate degree of extrarenal azotemia (see table 2) which gradually returned to normal in May of 1951. Fluid balance was observed, using the copper sulfate method.

On February 19 a bromsulfalein test showed

TABLE 2

Date	N.P.N. mg./100cc.	Total Protein Gm.	A/G Ratio	Albumin Gm.	Globulin Gm.
1/20/51	40.0	7.40	0.9:1.0	3.58	3.82
1/23/51	63.0	-----	-----	-----	-----
1/26/51	52.5	-----	-----	-----	-----
1/29/51	45.0	6.71	0.85:1.0	3.10	3.61
2/ 5/51	42.5	8.25	0.4:1.0	2.27	5.96
2/ 9/51	80.0	7.51	0.5:1.0	2.48	5.03
2/11/51	63.0	-----	-----	-----	-----
2/15/51	42.5	7.37	0.65:1.0	2.88	4.49
2/21/51	60.5	6.70	0.42:1.0	2.01	4.70
2/27/51	-----	7.02	0.46:1.0	2.18	4.84
3/ 7/51	32.5	6.50	0.6:1.0	2.56	3.94
3/ 9/51	29.5	7.20	0.55:1.0	2.55	4.65
3/17/51	51.0	6.80	0.5:1.0	2.31	4.56
3/26/51	53.5	7.40	0.7:1.0	3.06	4.34
4/ 4/51	-----	7.63	0.8:1.0	3.43	4.20
5/24/51	32.5	7.19	1.1:1.0	3.76	3.42
6/ 4/51	31.5	6.15	1.4:1.0	3.53	2.62
2/25/52	-----	6.10	2.7:1.0	4.45	1.65

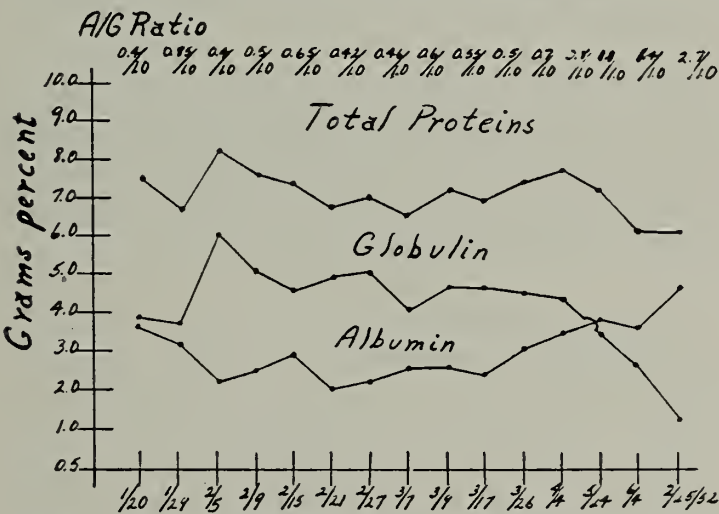


Fig. 3.—Note reversal of albumin-globulin ratio with normal total proteins from the first postoperative day, a gradual change to a normal albumin-globulin ratio not evident until the fourth postoperative month.

TABLE 3

Date	Bilirubin mg./100 cc.			Cephalin Flocculation
1/20/51	Direct	1 min	0.5	24 hours = 3 plus
	Direct	30 min	0.9	48 hours = 3 plus
	Indirect		1.1	
1/23/51	Direct	1 min	0.9	24 hours = 2 plus
	Direct	30 min	1.1	48 hours = 3 plus
	Indirect		1.4	
1/29/51				24 hours = 2 plus
				48 hours = 3 plus
1/30/51	Direct	1 min	0.50	
	Direct	30 min	0.80	
	Indirect		1.55	
2/ 5/51	Direct	1 min	0.0	24 hours = 2 plus
	Direct	30 min	0.45	48 hours = 3 plus
	Indirect		0.60	
3/16/51				24 hours = 2 plus
				48 hours = 2 plus

mild retention. The same test was normal on March 2. By May 24, 1951, all the foregoing studies had returned to normal, including the albumin-globulin ratio which was now 1.1:1.0. The thymol turbidity test was three units in the latter part of February and middle March, and was not repeated.

On February 25, 1952, one year after his initial injury, his total cholesterol was 186, cholesterol esters 72 per cent, total protein 6.1, and albumin-globulin 2.7:1.0. The bromsulfalein test was normal. The prothrombin time was 100 per cent, and the galactose tolerance test was also normal.

The foregoing tests reflect what could be interpreted as moderate liver cell damage. It is difficult to interpret the cholesterol values showing the normal esterification with abnormally low total cholesterol. It is possible that cholesterol was oozing from the laceration in the liver, possibly through the pleural cavity. Bile was found in the pleural fluid. The liver function, according to the liver function tests, was rapidly restored to normal and a year later was entirely normal with apparently no permanent damage to the liver.

COMMENTS

The mortality rate in traumatic rupture of the liver has improved markedly in the past several years. Numerous articles have appeared in the literature which show this decline. Mikal and Papen¹ presented an excellent review of 40 cases, studied between the years 1935 and 1945, which clearly show a 50 per cent decrease from an earlier total mortality of 62.5 per cent. This can be attributed to the recent advancement in the technique and additions to the surgeon's armamentarium. These are as follows:

1. Early surgery^{1, 6} or as soon as the patient's general condition is under control, should be accomplished. The work of Mikal and Papen¹ shows the mortality rate of nonoperative cases to have been 38.9 per cent. Madding² reported a mortality rate of 27 per cent in 829 patients with liver injuries during World War II regardless of the type of treatment used. We agree with Mikal and Papen, that Madding's series is not representative.

The larger lacerations of the liver, with more rapid development of physical signs, are no doubt responsible for the promptness with which surgery is undertaken. If the patient's blood pressure can be adequately controlled before operative procedure it is best to delay somewhat in order to improve the patient's condition. If this is not possible, surgical intervention should be undertaken if the patient is to be saved.

II. The use of absorbable gelatin sponge^{1, 3, 4} has played an important role in the mortality drop. It was not possible in this case, although attempted, to produce hemostasis with absorbable gelatin sponge because of the profuse bleeding. We do, however, agree that absorbable gelatin

should be used wherever possible to control the worst enemy, hemorrhage. It will be noted in this report that even suturing did not prove adequate to control the hemorrhage, partly because of the position of the laceration and the inaccessibility of the wound.

III. The use of antibiotics has been a great adjunct in control of infection, another of the enemies of this injury. The use of drains should be avoided, if possible, because of the frequency of the contamination of the wound. The intelligent use of antibiotics, with sensitivity tests, is of utmost importance.

IV. Whole blood transfusions and auto transfusions⁵ are of inestimable value.

V. Vitamins,⁶ methionine and liver extract⁷ have also been invaluable assets.

VI. Frequent determinations of the blood chemistry, including potassium,⁸ also played a part in the better results obtained.

Close observation of the patient is absolutely essential. The patient whose case is presented herein showed the following complications: shock; disturbances in salt balance, including potassium; secondary infection of the wound; disruption of the wound; sub-diaphragmatic abscess; hemothorax; pyothorax with abscess formation; toxic splenomegaly; intestinal obstruction; thrombosis of a major omental vessel; bilateral thrombophlebitis; and acute gastric dilatation.

It is felt that in this case the early recognition of the foregoing complications and the prompt and vigorous treatment thereof played a great part in the recovery of the patient.

SUMMARY

A case of a 25 year old colored male with a massive rupture of the liver is presented. Some liver function studies in a case of traumatic rupture of the liver are presented. The complications and their treatment are discussed. Early surgery, the use of gelfoam® for hemostasis, closure without drainage when possible, adequate use of whole blood, intelligent use of antibiotics, careful studies for salt balance, adequate hydration, and careful observation for complications are the important points in the treatment of traumatic rupture of the liver.

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KEEPING UP WITH MEDICINE

- YOUNG PEOPLE with a familial tendency to asthma or rhinitis should be informed about their predisposition to respiratory allergy before they start to train to become bakers.

* * *

- CHOLESTEROL in the blood increases in monkeys when they are changed from a diet with corn oil to hydrogenated vegetable oil. The same workers found that these monkeys had more or less cholesterol in their blood depending upon whether they were fed a high or low fat diet. Animals on a diet containing hydrogenated lard had more cholesterol in their blood and livers than animals on a diet containing an equivalent amount of cottonseed oil.

* * *

- BECAUSE of the danger of disseminating viral hepatitis all equipment contaminated with blood or used in handling blood products, all syringes, needles and lancets, should be used on only one patient and then sterilized by autoclaving or boiling. Blood plasma should never be used indiscriminately and only if prepared from relatively small pools.

Persons with a history of having had viral hepatitis should not be used as donors. Zinc turbidity reactions may be readily determined on aliquots of blood and all positive units should be thrown out.

* * *

- HYPODERMIC INJECTIONS of epinephrine must be used carefully in bronchial asthma because the excessive use of sympathomimetic drugs may result in status asthmaticus. Morphine, too, has no place in the treatment of bronchial asthma.

* * *

- INSTEAD of seeking for unsaturated fatty acids as required by our bodies, it is now suggested that we add 15 per cent of soy sterols to our butter. Why not country butter in the first place rather than another fortification of food? Anyway, they tell us we had better fry our eggs in peanut oil. Then the cholesterol will not be increased in our blood and livers.

* * *

- A HIGH concentration of the sodium-retaining principle presumed to be or known to be aldosterone occurs in edematous patients with nephrosis, decompensated cirrhosis, congestive heart failure, and toxemia of pregnancy. Such conditions are examples of secondary aldosteronism.

* * *

- SINCE Rich and Gregory were able in 1943 to produce periarteritis nodosa in rabbits by the administration of horse serum with or without sulfadiazine, other agents have been indicated as antigens and held responsible for the production of the disease in human beings. They include penicillin, dilantin,[®] poison oak, mercurials, thiourea, iodine, and the steroids.—J. F.

An Improved Acne Cleanser

BENJAMIN LEVINE, M. D.

THE importance of proper and thorough cleansing of acne skins has long been recognized. Unfortunately the soaps, detergents and solvents sufficiently active to remove and dissolve the excessive secretions, oils, grease, follicular plugs, etc., characteristic of this disease, have frequently proved irritating and sensitizing. Milder cleansers, although non-irritating, are not sufficiently powerful to successfully wash the acne area free from oil and debris.

This perplexing situation is further complicated by the indifferent adolescent attitude towards proper skin hygiene, so that this important aspect of acne therapy is frequently neglected unless definitely emphasized by the physician.

FACTORS FOR IDEAL ACNE DETERGENT

Over a period of years during which we have tried numerous soaps for this purpose, each of which had certain advantages and disadvantages, it became obvious that a number of properties are apparently required by an ideal acne cleanser to satisfy some of the problems enumerated.

This detergent must be—

1. Soap free—since the alkalinity and perfume of soaps are frequently sensitizers.
2. Mild—but sufficiently active to cleanse thoroughly and completely.
3. Nonabrasive—since excessive friction and abrasion may cause irritation.
4. Nonalcoholic—since volatile detergents are excessively drying and occasionally irritating.
5. Antiseptic—to protect the skin against secondary bacterial invasion.
6. Grease miscible—the emulsification, solubilization and removal of excess sebum is a primary requisite for a good acne cleanser.
7. Pleasant to use—to secure patient cooperation, because cleansing may have to be as frequent as four to five times a day, in patients with very oily skins.
8. Free from grease, fat, oils, etc.—since adding more grease to an already excessively oily skin is contraindicated.
9. Provide a rich lather in cold and/or hard water—since many patients live in hard water areas and do not secure sufficient suds from soap to rinse adequately.

For the past year, we have employed a soapless acne detergent which we firmly believe possesses all the qualities described. It contains no soap, perfume, alkali, abrasives, oils, fats, alcohol, acetone, etc. It has a pH of 5.5 approximating that

Submitted November 14, 1955.

The Author

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of the skin and lathers copiously in acidic media, hard, soft, cold or hot water.

In over 150 cases of acne vulgaris, we have not encountered a single case of irritation or sensitivity due to its use. It is mild, but superior to the harshest soaps and synthetic detergents, in eliminating excessive grease and sebaceous secretions. It has proven a valuable adjunct in the emulsification and removal of grime, oil, dirt, plugs, etc. It aids in preparing the acne site for optimal therapeutic action by the medicinal agents subsequently employed.

Fomac®* is a mixture of an ether-sulfonate complex with cyclo-imidine carboxylates. This detergent contains 2 per cent hexachlorophene in micronized form in which concentration it has proven to be a valuable aid in decreasing the incidence of pyogenic skin infections and reducing the bacterial flora of the skin.¹ This antibacterial and bacteriostatic action is cumulative.² Thus this detergent not only cleanses the skin but in addition, by virtue of its excellent foaming and powerful cleansing action, fomac® mitigates against the formation of new follicular plugs.

Most concentrated strong soaps and detergents are harsh and irritating to the epidermis. In contrast, laboratory studies conducted by independent agencies, with the detergent constituents of fomac® exhibited no irritating qualities. Olive oil castile shampoo, used as a basis of comparison under the same conditions yielded a 2 plus definite reaction.

In addition these constituents were tested for eye irritation in accordance with the method of Draize and Kelley on the eyes of rabbits. They were examined after 1, 24, and 48 hours and no evidence of conjunctival redness, chemosis or discharge could be detected indicating the safety factor as 100 per cent.

*Fomac® (Soapless Acne Detergent)—Dermik Pharmacal Co., Inc., Brooklyn 8, N. Y.

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Omphalocele in General Practice

Presentation of a Case

PERRY R. LONGAKER, M.D., and GLENN J. GREER, M.D.

THE occurrence of an omphalocele is an unusual and infrequent congenital anomaly. It presents itself to the general practitioner doing obstetrics, the obstetrician, and the general surgeon as a challenge and problem demanding immediate and proper treatment. This is especially true in those smaller urban and rural communities where, occasionally, both time and distance preclude the referring of the baby to a larger center for surgical care. Furthermore, there is no reason why the adequately trained general surgeon should be reluctant to treat these emergencies.

The average physician, in the course of a lifetime of practice may never see an omphalocele; and at the most, may encounter only one or two. If such cases, under these conditions, are to be given the care they deserve, a definite and ready knowledge of the cause and treatment of the omphalocele must be known.

The purpose of this paper is to describe as concisely as possible the embryological explanation, the physical findings, symptoms, and treatment and to present the actual case of a newborn baby successfully treated. Nothing new has been suggested or added other than a plea for prompt, skillful, and minimal, yet essential, surgical treatment. The occasional attitude of futile hopelessness resulting in needless death is to be deplored.

EMBRYOLOGICAL DEVELOPMENT

One will recall that in the early embryo, the intestinal tract is a straight, tubular structure suspended in the sagittal plane of the body. By a process of "intestinal rotation," this primitive position is converted into the position occupied at birth. The primitive intestinal tract is divided into the foregut (mouth to duodeno-jejunal junction); midgut (duodeno-jejunal junction to mid transverse colon); and hindgut (mid transverse colon to anus) and the process of rotation has been divided into three stages. As the primary intestinal tube lengthens out, it grows faster than the celomic cavity allowing the midgut loop to protrude through the umbilical orifice into the primitive umbilical cord to form a temporary physiological umbilical hernia.

At about the eighth week of intrauterine life, the intraumbilical loop rotates 90° in a counter-clockwise direction from the original sagittal to the horizontal plane, and this constitutes the first stage of rotation. When further rotation beyond this stage does not take place and the

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midgut is retained in the umbilical stalk at birth, the condition is known by various names, such as: an exomphalos, amniotic hernia, umbilical eventration, funicular hernia of the umbilicus, hernia into the cord, or best, an omphalocele. There is then usually some permanent difference in size between the abdominal viscera and the peritoneal cavity. This can be due either to the abnormally large viscera or to the retarded development of the peritoneal cavity or to both.

DESCRIPTION OF SAC

The covering of this sac is the thin, translucent, umbilical cord structure made up of peritoneum internally and amniotic membrane externally and is not covered by skin which usually stops at the base of the omphalocele or more rarely extends more than one or two centimeters above this. To the apex of the sac is attached the stump of the umbilical cord, and spread over the surface of the sac are the three umbilical vessels coursing to the abdominal wall.

The size of the omphalocele may vary from several centimeters in diameter to one that is 25 to 30 centimeters in diameter, the average being 6 to 8 centimeters. The size of the protruding mass is in no way related to the size of the abdominal wall defect which may vary from 4 to 5 centimeters to twice as large.

The contents of the sac may vary greatly. Through the thin covering one can see that it usually contains multiple loops of small intestine; sometimes portions or all of the stomach, spleen, pancreas, and urinary bladder; about one-third of the time it contains the transverse colon; and in one-half of the cases, some part or all of the liver. The presence of and the amount of the liver in the sac has seemed of definite prognostic value, for it implies that the peritoneal cavity is unusually small, and that there will be difficulty in reducing the omphalocele and closing the abdominal defect. It has been shown quite certainly that the greater the amount of liver present within the sac, the poorer the prognosis, and consequently the higher the mortality rate.

In most series of omphaloceles reported, more

than 50 per cent are accompanied by other congenital abnormalities including clubfeet, inguinal hernia, harelip, imperforate anus, Mickel's diverticulum, undescended testicles, et cetera. The baby, in the case presented below, has bilateral indirect inguinal hernias.

The sac wall is at first moist, translucent, pliable, and will stand a certain amount of gentle handling but within 24 hours it becomes dry, shriveled, opaque, friable, and easily subject to rupture. Such an accident results in immediate evisceration and almost always fatal peritonitis. The intact sac, probably because of its poor blood supply, is very poorly resistant to bacterial invasion.

SURGICAL PROCEDURE

Because of the preceding conditions, immediate surgical intervention is needed if the baby is to survive. If the baby can be operated upon immediately after birth, while it is still well-hydrated, before the intestinal tract has become distended with gas and food, and while the covering sac is still free from infection, the outcome is much better than if surgery is delayed longer. As the mortality rate varies from 30 to 50 per cent, it is our feeling that the operation which can accomplish the desired result in the shortest period of time and with the least amount of shock is the one to be desired.

The operation must consist of excision of the sac, replacement of the various viscera within the peritoneal cavity if possible, and closure of the defect in the abdominal wall, or, at least, the formation of a covering of skin and subcutaneous tissues. After the sac has been excised, and if the viscera have been successfully returned to the abdominal cavity, the simplest and quickest means of bringing the operation to an end is to freshen the edges of the presenting ring and close the abdominal wall with interrupted through-and-through sutures, making no effort to close it in layers. Later on secondary operations for a more definitive layer-to-layer closure can be done when the baby is older and more able to stand a lengthy surgical procedure.

The following case may be of interest because it was treated successfully by the method described in the foregoing in spite of the fact that the entire liver, most of the small intestine, transverse colon, stomach, and gallbladder were contained in the omphalocele. We must, of course, realize that there was not in this case too great a disparity in size between the abdominal viscera and the peritoneal cavity.

CASE REPORT

The patient, a baby girl, was delivered spontaneously by Dr. G. G. at the Brown Memorial Hospital, Conneaut, Ohio, at 12:59 p. m. on May 9, 1954. She cried immediately, her color was good, and she weighed 6 pounds 2 ounces. She appeared normal in all respects except for a large mass, about 12.5 to 13.0 centimeters in diameter, protruding from the umbilicus, through

the translucent covering of which could be seen the liver, stomach, and multiple loops of small intestine.

As her general condition was good, she was taken to surgery one hour following delivery and anesthetized with light drop ether together with constant intranasal oxygen. The sac was opened (its contents have previously been stated) and excised. It was necessary to free it at several points where it was adherent to the liver. The small bleeding areas on the surface of the liver were controlled by pressure and hot packs. It was then found that the entire liver and remaining viscera could be reduced into the abdominal cavity with only moderate difficulty and without creating too great pressure upon the diaphragm or the great abdominal vessels. The edges of the abdominal wall defect, which measured 7.5 by 3.75 centimeters, were then freshened around the entire ring and the wall closed with closely placed through-and-through interrupted black silk sutures.

The postoperative course was uneventful and the wound healed primarily. In the incisional area there subsequently developed a bulging and weakness of the abdominal wall. On January 14, 1955, a secondary operation was done at which time a layer-to-layer closure was accomplished. She again made an excellent recovery without complications. Now at the age of 11 months she appears to be in excellent health, her abdominal wall is firm, and she weighs 18½ pounds.

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Specific Acquired Sensitivity Follows Distinctive Pattern

Eczema of the hands due to specific acquired sensitivity is not nearly as common as eczema due to primary irritation, but when it does occur, it may be recognized by its distinctive pattern. G. L. Waldbott has listed the patterns in his book, *Contact Dermatitis*, which is a valuable aid and time saver for the busy practitioner who seldom can afford the time-consuming effort of discovery by interrogation. Recently a new pattern has been added: that due to holding onions and garlic. This eruption characteristically involves the distal palmar aspect of the thumb, index and middle fingers of the left (holding digits) and the thumb of the right hand (grasping digit). Patch tests to extracts of these and allied plants confirm sensitization. Other patterns may occur from sensitization to nickel (rings), chrome (bathroom fixtures), and plastic materials (handles).—James W. Burks, Jr., M. D., New Orleans: *J. Oklahoma State M. A.*, 48:208, 1955.

Transfusion Hazards; Report of a Case Demonstrating A Reaction to the P Factor.

GEORGE R. DOCHAT, M.D.

PRESENT-DAY transfusion services in the modern hospital are a vast improvement over similar services offered but 5 or 10 years ago. Some of the advances are due to an increasing availability of blood; much of the improvement, however, is due to increasing technical knowledge particularly in respect to a recognition of many additional blood factors and an appreciation of their immunological behavior. Slow progress in our knowledge of the various blood factors was initially made following Landsteiner's identification of the major ABO groups at the turn of the century. The identification of the Rh factor in 1940 by Landsteiner and Wiener produced a marked acceleration in our knowledge of additional blood factors.

Since 1949 numerous additional blood factors have been identified by various workers in the field of immunohematology. These have been given various letter and name designations. Thus the original ABO group designations have grown to embrace the various Rh-hr groupings, including the weak Du factor and the other rarer factors such as the Kell-Cellano (K), the Duffy (Fy), the P, S, M, N, Jk, Le, Lu, etc.¹ Probably others are yet to be encountered and subsequently identified.

The hazards of a single transfusion of supposedly compatible blood are many. These hazards are multiplied in proportion to the multiplicity of transfusions being used these days for some individual patients. We are all familiar with such hazards or reactions as homologous serum hepatitis, allergic and pyrogen reactions, circulatory "overload," citrate dilution, bacterial contamination of stored blood, and the dangerous hemolytic reaction due to the transfusion of actual incompatible blood. Clerical and technical errors, coupled with the ever increasing numbers of personnel handling blood from the time it is drawn from the donor until it is given to a recipient magnify actual or potential hazards which may be encountered.

All of this should serve to focus the attentions of all involved in a blood transfusion procedure, including the physician ordering such, that this is a serious undertaking, not to be lightly considered, and one which is potentially dangerous for the recipient. Thought must be given to the possibility of producing iso-immunization in a recipient to one or more of the many different

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blood factors now recognized. The initial transfusion may be accepted by the recipient without event; subsequent transfusions may produce mild or severe reactions due to such iso-immunization; in the woman of child-bearing age, erythroblastosis of mild or severe degree may be the result of such iso-immunization.

It seems pertinent to note that care and consideration are essential in the ordering of a blood transfusion and the need for such should be definitely indicated. The promiscuous and unwarranted use of blood may result in difficult or incompatible cross matches for subsequent transfusions, produce undue expense for the patient and expose him or her to the hazards and complications of iso-immunization. Such subsequent blood may be lifesaving for the recipient; it is basically a disservice to that recipient to induce possible sensitization to one or more blood factors by previous transfusions, the indications for which were not clear-cut.

It is the lot of physicians and technologists in this field to ferret out such iso-immunizations in the recipient and provide compatible blood, not only from the standpoint of the ABO and Rh-hr groups, but also from the standpoint of the lesser known blood factors many of which are capable of producing such iso-immunizations. The difficulties in such procedure are well illustrated by the following case:

REPORT OF A CASE

Mr. —, is a 62 year old white male who in 1940 (elsewhere) had a cholecystectomy. During the course of this hospitalization he received several transfusions all of which were accepted without reaction. His first admission to Akron General Hospital was in January 1956 for a hemorrhoidectomy and removal of prolapsed rectal mucosa. The patient was group O, Rh positive (CDE) and preoperatively was given 2 pints of compatible blood (500 ml. each on successive days). The first pint was accepted without reaction. After 150 ml. of the second pint was given, chills and restlessness developed and the transfusion was discontinued. Temperature rose

¹Submitted April 16, 1956.

to 100.8° but fell promptly and there was no urinary suppression or hemoglobinuria.

The next admission was in March 1956 at which time he complained of anorexia and abdominal pain. After suitable diagnostic study an exploratory laparotomy seemed indicated. The attending surgeon requested 4 pints of compatible blood available for surgery with one of these to be administered the day prior to the elective surgical procedure. Compatible blood was prepared from pints of group O, Rh positive blood supplied by the Cleveland Regional Blood Center of the American Red Cross. Saline and high protein cross match procedures at room temperature were done.

The preoperative blood was discontinued after administration of approximately 60 ml. The patient first complained of chilling with the chills rapidly becoming violent. A temperature elevation to 105.6° was recorded three and one-half hours after starting the blood. Symptomatic therapy controlled the extreme temperature rise and by the following morning, the temperature was normal. Urine output was unaffected and there was no hemoglobinuria. The contemplated surgery was cancelled; the case was not re-scheduled until the attending surgeon could be assured of the availability of compatible blood.

The blood given which produced this violent reaction was rechecked for compatibility by saline, high protein, and indirect Coombs cross match procedures at room temperature. Compatibility was again demonstrated by the saline and high protein methods; the indirect Coombs cross match was incompatible. All subsequent transfusions for this patient were prepared by the latter cross match procedure at room temperature. A total of 30 pints of group O, Rh positive blood were screened and from this group 7 pints were found compatible for the patient.

He was again scheduled for surgery. Three pints of blood were given preoperatively with an additional pint given during the course of surgery. An exploration of the common bile duct along with the incision and drainage of a liver abscess were done. There was no reaction on the part of the patient to any of the blood transfusions. No blood was administered postoperatively and the patient was discharged improved 12 days following surgery.

Subsequent studies of the patient's blood were kindly done for us by Dr. Philip Levine. He demonstrated the presence of an atypical antibody active mainly at lower temperature and corresponding in specificity to anti-P. He suggested that compatible P negative bloods be selected by the indirect Coombs cross match procedure at room temperature and also at 37° C. temperature.

COMMENT

The foregoing case would seem to indicate the development of iso-immunization to the P factor. We feel that such initial sensitization probably occurred at the time of the administration of blood in 1940; such sensitization possibly was reinforced by the second pint of blood given in January. A florid febrile reaction ensued then to the first pint of blood given at the March admission. The compatible bloods eventually prepared for the patient were undoubtedly P negative and as such were used without reaction in a P negative recipient. Our recovery of 7 pints

of compatible blood from the 30 pints screened would correspond approximately with the incidence of the P factor in human beings.

Rosenfield et al.² in a recent report analyzed 38,000 blood specimens and reported but four instances of P iso-immunization. Most investigators in the field are of the opinion that P sensitization is of no or little clinical significance. In our case, it is true that no apparent hemolytic reaction was induced. The patient did have a most severe febrile reaction. Even more important, clinically, was the fact that surgery was denied this patient until suitable donors were obtained and the surgeon assured of the availability of compatible blood.

The increased use of blood presents now a very real problem for the patient, attending physician, and transfusion service-blood bank personnel. As already indicated these rare blood factors are capable of iso-immunization; we anticipate increasing hazards in transfusion work because of the increased use of blood with a direct multiplication of possible recipient sensitization. The blood bank-transfusion service attempting to cope with this possibility may find it desirable to use only the indirect Coombs cross match procedure as a routine match, and discard other methods as saline and high protein cross matches.

The indirect Coombs cross match method is capable of detecting recipient iso-immunization to factors present in the donor's blood. By panels of known testing cells, it is possible then to determine the factor or factors responsible for such iso-immunization. As Levine points out, it may be desirable for such testing to be carried out in research laboratories especially equipped for such studies.

SUMMARY

1. A case of apparent P iso-immunization is presented showing a severe febrile transfusion reaction.

2. The possibility of sensitization by blood transfusion to one or more of the rarer blood factors now known or subsequently to be discovered is emphasized.

3. A plea is made for the judicious use of blood transfusion, particularly in the female of child-bearing age in order to avoid or minimize the dangers of such sensitization.

4. The indirect Coombs cross match technique procedure is suggested as a desirable routine for blood bank-transfusion service use to detect recipient iso-immunization.

Acknowledgment.—The technical assistance of Miss Vivian Youngman, M. T. (ASCP), is gratefully acknowledged.

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Prednisone and Prednisolone Therapy in Rheumatoid Arthritis: A Gastrointestinal Hazard?

NORMAN O. ROTHERMICH, M. D., and VOL K. PHILIPS, M. D.

THE hazards inherent in the use of adrenal steroids in continuous treatment of patients with chronic disease are well known to all practicing physicians. In the past year, the development of two new synthetic crystalline steroids, prednisone and prednisolone, was welcomed by clinicians as an improvement upon their structural analogues cortisone and hydrocortisone respectively. Boland¹ reports prednisone and prednisolone possess greater propensity for production of digestive complications than the earlier drugs. He found an incidence of gastric complaints simulating those accompanying peptic ulcer in 37 per cent of patients during treatment with the new steroids. By comparison, these symptoms occurred in only 7 per cent of his patients while on hydrocortisone therapy. He also commented that gastrointestinal complaints became more troublesome following transfer to therapy with the newer steroids.

This report of such high incidence of gastrointestinal side effects may cause serious concern to any physician using prednisone and prednisolone in treatment of rheumatoid arthritis. Therefore, we thought it worth while to review our own material to see if such caution were necessary.

SELECTION OF PATIENTS AND OUTLINE OF TREATMENT

Our series of 95 patients with proven rheumatoid arthritis, peripheral or spondylitic, were seen in the first three months of 1956 at the Columbus Medical Center. Of these, 63 patients have received or presently are receiving oral adrenal steroid therapy. All patients have currently active disease and are pursuing their usual occupations with their symptoms suppressed by salicylate, barbiturate, intermittent physical medicine, and other supportive therapies which form the baseline for symptomatic control of the disease. The patients have been observed from periods of from one month to four or more years under continuous therapy.

The 63 patients on steroid therapy represent 73.5 years of active steroid therapy (table 1). Most of the patients now on prednisone or prednisolone have been transferred to these preparations from the earlier drugs. As such, 93 patient courses of steroid therapy have been undertaken. The average duration of continuous steroid therapy was 20.6 months in the case of cortisone; eight months for hydrocortisone; five and eight-tenths

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months for prednisone and two months for prednisolone (table 2).

Average daily maintenance doses of prednisone and prednisolone were in the order of 10 mg. per day, roughly one fourth to one fifth that required for maintenance of satisfactory clinical state with cortisone or hydrocortisone (table 4).

RESULTS

In our series, no patient on cortisone developed a gastrointestinal complaint or disturbance. One patient out of 18 on hydrocortisone developed a gastrointestinal upset lasting two weeks with diarrhea while on hydrocortisone, 40 mg. per day (table 3). This patient continued his hydro-

TABLE 1.—PATIENT YEARS ON THERAPY

Steroid	No. Patients	Patient Months Rx.	Patient Years
Cortisone	22	453	37.8
Hydrocortisone	18	142	11.8
Prednisone	48	278	23.2
Prednisolone	5	9	0.7
Totals (63 patients)	93	882	73.5

TABLE 2.—MONTHS ON CONTINUOUS THERAPY

Steroid	Minimum Duration	Maximum Duration	Average Duration
Cortisone	2	48	20.6
Hydrocortisone	2	19	8.0
Prednisone	1	12	5.8
Prednisolone	1	3	2.0

TABLE 3.—GASTROINTESTINAL COMPLAINTS

Steroid	No. Patients	G. I. Disturb.	Site
Cortisone	22	0	
Hydrocortisone	18	1	Upper
Prednisone	48	5	{ 4-upper 1-lower
Prednisolone	5	0	

Submitted May 16, 1956.

cortisone medication during his illness and recovered uneventfully. Five of 48 patients on continuous prednisone therapy developed gastrointestinal disturbances. One of these, a 45 year old white male with rheumatoid arthritis of one year's duration developed massive gastrointestinal bleeding while on prednisone, 10 mg. per day. Intensive efforts to find the source of bleeding were to no avail, but probabilities strongly favored rectal origin. History revealed that he had had a similar episode three months prior to the one described, but had not been hospitalized. He was removed from prednisone therapy and symptomatic therapy re-instituted. It should be emphasized that the patient had no symptoms of upper gastrointestinal distress of any kind.

A second patient who had previously received cortisone for four years without gastrointestinal complaint, developed epigastric pain after three months of prednisone therapy at 15 mg. per day. This patient was found to have a diverticulum of the stomach by gastrointestinal series and endometriosis by diagnostic laparotomy. This

TABLE 4.—STEROID DOSAGE RELATED TO GASTROINTESTINAL DISTURBANCE

Steroid	Av. dose	Av. dose
	per day All Patients	per day G. I. Patients
Cortisone	50mg	-----
Hydrocortisone	40mg	40mg
Prednisone	10mg	10mg
Prednisolone	10mg	-----

patient remains on prednisone and is receiving antispasmodics, has periodic abdominal discomfort believed related to her endometriosis.

A third patient, a 51 year old white female with rheumatoid arthritis of four and a half years' duration had been on cortisone and later hydrocortisone therapy without symptoms other than edema. She presented symptoms of painful swallowing and burning substernally only after ten months' therapy on prednisone. Barium swallow fluoroscopy was negative and the symptoms have abated without alteration of therapy.

A fourth patient who developed epigastric distress after three months' therapy with prednisone, 10 mg. a day and butazolidin,® 400 mg. a day, was found to have a normal gastrointestinal series. On treatment with pro-banthine® and magnesium tri-silicate, the gastrointestinal symptoms abated and prednisone therapy was continued without further event.

A fifth patient with rheumatoid arthritis and spondylitis had been shown by gastrointestinal series prior to therapy to have a deformed duodenal bulb and pylorospasm. She had intermittent episodic gastrointestinal distress. Prednisone therapy intensified this distress after 20 days. She was subsequently transferred to prednisolone, 15 mg. daily with protective medication and has had no further gastrointestinal distress.

The final patient developed bloating and belch-

ing while on prednisone, 5 to 10 mg. daily. She was transferred to prednisolone therapy and given gelusil® to use as needed. She has had no further gastrointestinal distress.

Review of tables 3 and 4 reveal the low incidence of gastrointestinal complications of adrenal steroid therapy for rheumatoid arthritis. The dosage requirement for daily maintenance is quite low in the patients treated with the metisteroids, usually in the range of 10 to 15 mg. daily. The relatively low dosage requirement, together with the physician's explicit and repeated instruction to the patient to take his adrenal steroid immediately after eating, may in part account for the relatively low incidence of gastrointestinal complications in our series.

In view of our findings, it is believed that with this low incidence of gastrointestinal complications, prednisone and prednisolone constitute no gastrointestinal hazard to the patient. Certainly the incidence is far below that seen in patients receiving the larger doses of salicylates or of phenylbutazone. The continuous administration of alkalinizing agents may constitute a serious threat to the patient from acid-base and renal complications.

SUMMARY

Of 95 patients with proven rheumatoid arthritis, peripheral or spondylitic, seen in the first three months of 1956 at the Columbus Medical Center, 63 have received or presently are receiving oral adrenal steroid therapy. Of these, only six have developed a gastrointestinal complaint. One occurred while the patient was on hydrocortisone, five occurred in patients on prednisone. None occurred in patients on cortisone or prednisolone therapy. Of the five patients developing gastrointestinal disturbances while on prednisone, only two could be said to have reacted adversely to the administration of prednisone.

Our observations indicate that prednisone and prednisolone may be used continuously in patients with rheumatoid arthritis without undue gastrointestinal hazard. Further, the addition of antacids or antispasmodics to the metisteroid administration, whether combined with the steroid or separate from it, appears unwarranted.

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Aural Vertigo

Local evidence of chronic ear disease such as foul discharge, dull headache on the side of the affected ear and vertigo of any grade with or without nystagmus, is an urgent indication for hearing record, x-ray study of the mastoid and prompt surgical treatment of the chronic mastoiditis.—James B. Costen, M. D., St. Louis: *Missouri Med.*, 53:669, August, 1956.

Primary Carcinoma of the Fallopian Tube

REID P. JOYCE, M. D.

TODAY, when attention is being focused on malignancy and especially its early detection to a greater degree than at any time in the history of medicine, it is essential that we alert ourselves to the necessity of thinking of malignant growths in structures which ordinarily do not show such lesions.¹

In this light it is hoped that correlation of symptoms and physical findings might define a more suggestive pattern in enabling one to recognize the existence of a malignant lesion by purpose rather than by accident—as is the usual experience of most individuals reporting unusual new growth. That the prognosis is notably poor attests to the fact that most primary carcinomas of the fallopian tube have been discovered too late for definitive surgery to be curative.²

A review of the literature emphasizes the significance that must be accorded abnormal bleeding from the generative tract and abnormal discharges coming from the generative tract.

Etiologically, the literature has contributed very little to cause one to suspect carcinoma of the fallopian tube except to state that 66 per cent of cases occur in patients between the ages of 40 and 55, and that old inflammatory process within the tube is of relatively frequent occurrence as an associated finding.⁴

SYMPTOMATOLOGY

Some degree of low abdominal discomfort, ususally not severe, associated with a watery or serosanguinous discharge is usually present. In the premenopausal patient some irregularity of the menses may be elicited. Of greatest importance is the appearance in the postmenopausal patient of a watery or serosanguinous discharge of more or less intermittent character which cannot be explained by biopsy or curettage. Parsons points out that pain appears early in primary carcinoma of the fallopian tube—in contrast to pain resulting from carcinoma of the endometrium or ovary.

Hydrops tubae profluens as described by Latzko in 1915 is characterized by intermittent, colicky, low abdominal pain, relieved by a sudden gush of watery or serosanguinous discharge from the vagina. This history should alert the physician to the possibility of existing tubal malignancy. Interestingly, many physicians obtain a history of this character, only to be con-

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fronted with negative pelvic and vaginal findings when the patient is examined. It must be assumed that the history is accurate and that the discovery of no palpable tumor implies the emptying of tubal fluid content.

PHYSICAL FINDINGS

With the exception of a case, recently reported by Mitchell and Mohler,³ of primary carcinoma in a segment of one tube removed during a bilateral resection of the tubes for purposes of sterilization, almost always a mass can be palpated in the region of one or both adnexae. Seventy per cent of fallopian tube carcinomas are unilateral. Large masses, associated with or without abdominal ascites usually denote advanced malignancy.

PATHOLOGY

At the operating table, when metastatic evidence of malignancy is lacking, the presence of unilateral or bilateral tubal enlargement may not suggest the existence of an intraluminal malignant growth. The finding of hematosalpinx in the postmenopausal patient should strongly suggest the presence of an intraluminal growth. The surgeon should examine the contents of such a tube before completing the operation. This is because a bilateral salpingo-oophorectomy and complete hysterectomy is considered essential in the complete management of any operable patient with a carcinoma of the tube. Supporting this statement is the fact that approximately 30 per cent of these primary carcinomas occur bilaterally.

In not a few of the earlier reported cases of primary carcinoma of the fallopian tube many pathologists have cast doubt as to the specific primary character of the neoplasm in the tube itself.⁴

The most common site of a primary carcinoma in the tube is in its distal two-thirds. That the fimbriated end of the tube is so frequently sealed apparently accounts for the fact that discharge or "spill" must occur via the vagina.

It would appear reasonable to expect help

Submitted July 11, 1955.

from exfoliative cytological studies but I have been able to find reference to only one such positive report.

The microscopic pathology is well described in most texts on pathology and will not be repeated here. Metastasis occurs via the lymphatics and by contiguity and continuity.

TREATMENT

The only hope for a cure is the removal of both tubes and ovaries and the uterus in those instances in which the disease is still confined to the tube itself. Irradiation therapy offers nothing after metastasis has occurred and is not generally used as an adjunct to surgery.

CASE REPORT

Mrs. —, a 57 year old married but nulliparous white woman was first seen on August 7, 1950, complaining of a pinkish vaginal discharge which she first noticed five days earlier. The menopause occurred in 1941 following x-ray therapy for pruritis vulvae and pruritis ani. Thirty years ago she had a "ruptured appendix" and this was followed three years later by appendectomy. In 1935 two benign tumors were removed from the left breast. In 1938 she had a left salpingectomy and resection of a cyst from the left ovary. The pathological report: Follicular ovarian cyst; chronic cystic salpingitis.

On physical examination the surgical scars on the left breast, a low midline, a McBurney's and a right lower rectus scar were not remarkable. Pelvic examination revealed a normal perineum, a nulliparous cervix possessing two Nabothian cysts and the presence of a small amount of old brown blood in the vagina. The uterus was anterior, freely movable, tender to manipulation and slightly irregular in outline although not enlarged. The adnexae were not palpated.

Cytological studies of the bloody vaginal discharge revealed no atypical cells. All laboratory studies including sedimentation time were within normal limits.

A diagnosis of uterine bleeding, cause undetermined, possibly endometrial polyp, was made. On September 12, 1950, a diagnostic curettage and cervical biopsy were done. Only a tiny fragment of endometrium was obtained by curettage. The pathologist reported the cervix to show no evidence of carcinoma and the endometrial fragment showed fibrous stroma only.

Convalescence was uneventful. The patient left for a vacation after being examined on September 25. Re-examination on October 27, 1950, revealed an agglutination of the external cervical os. This was opened by inserting a probe into the os and about one ounce of serosanguinous fluid escaped from the uterine cavity.

Re-examination on November 3, 1950, again disclosed the cervix to be occluded and on pelvic examination a cystic mass was palpated in the region of the right adnexae, suggesting the presence of a large fallopian tube or a cystic ovary. On two subsequent office visits serosanguinous fluid was released from the uterus by inserting a probe into the cervical canal. The diagnosis then was made of (1) degenerating uterine fibroid with bleeding and (2) right ovarian cyst with chronic right salpingitis.

On November 28, 1950, approximately two and one-half months following the diagnostic curettage, a celiotomy was done. The findings were as

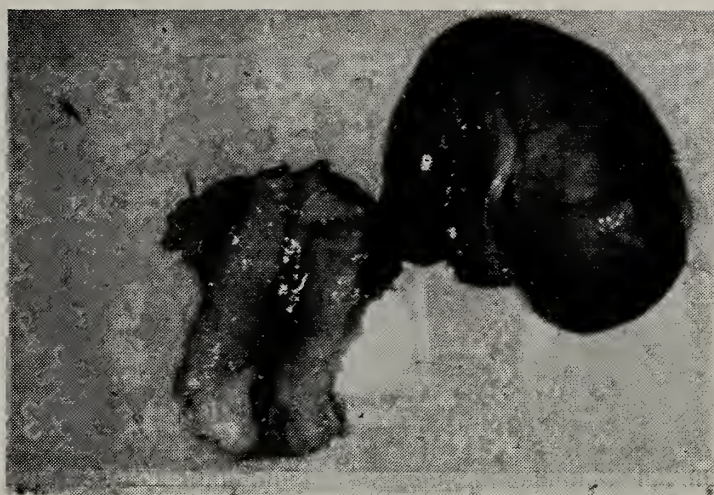


Fig. 1(A). Uterus and attached right fallopian tube.



Fig 1(B). Right fallopian tube opened. Note malignant growth in fimbriated end of tube.

follows: The cervix was normal in appearance; the uterus was atrophic but adherent to the omentum, giving rise to its irregular contour as described following bimanual examination; the left tube and most of the left ovary had been removed at a previous operation. The right tube was markedly distended with serosanguinous fluid. [Fig. 1(A) and Fig. 1(B)].

The right ovary was markedly atrophic. The greater omentum was adherent to the anterior parietal peritoneum, the uterus and to the sigmoid colon. The appendix had been previously removed. The gallbladder contained no stones and was normal to palpation. The gastrointestinal tract, kidneys and liver were normal to examination.

A complete hysterectomy, right salpingectomy and bilateral oophorectomy were done.

Microscopic pathological study showed atrophic endometrium with moderately advanced involutional changes in the myometrium. The cervical tissue was benign. Sections of the fallopian tube showed the mass to be composed of adenomatous hyperplasia. (Fig. 2.) Mitoses were few but there were, to a moderate degree, atypical nuclei and nucleoli. (Fig. 3.) In many areas there were atypical alveoli in solid clumps of cells. No invasion of the tube wall was seen. Adjacent benign mucosa of the tube wall was atrophic and flattened, with rare lymphocytic cells in the stroma. (Fig. 4.) *Diagnosis:* (1) Senile involution of the uterus, (2) Primary adenocarcinoma (papillary) grade I, of the fallopian tube.

COMMENT

A case of primary carcinoma of the fallopian tube is reported. The diagnosis was not correctly made preoperatively. However, when the uterine curettage and cervical biopsy failed to explain the cause of the uterine bleeding and

abdominal discomfort, the later finding of an adnexal mass followed by celiotomy did establish the correct diagnosis. It is hoped that the failure to find evidence of metastasis to the muscularis or the serosa of the involved tube may permit a surgical cure for this patient. She is alive and well five years after her surgery.

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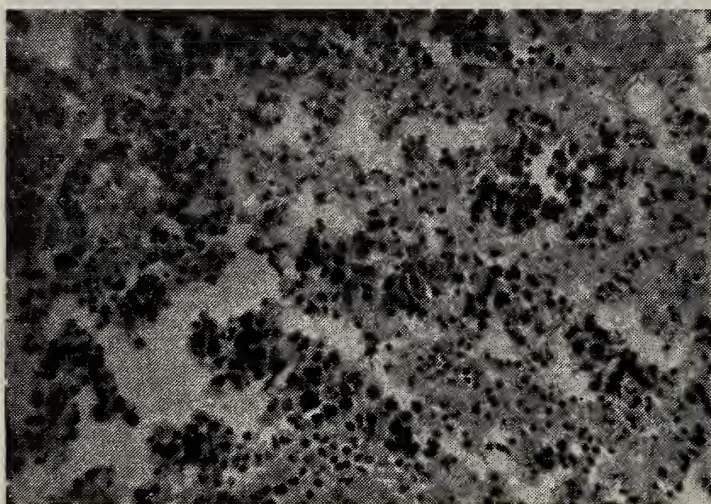


Fig. 2. Adenomatous hyperplasia.

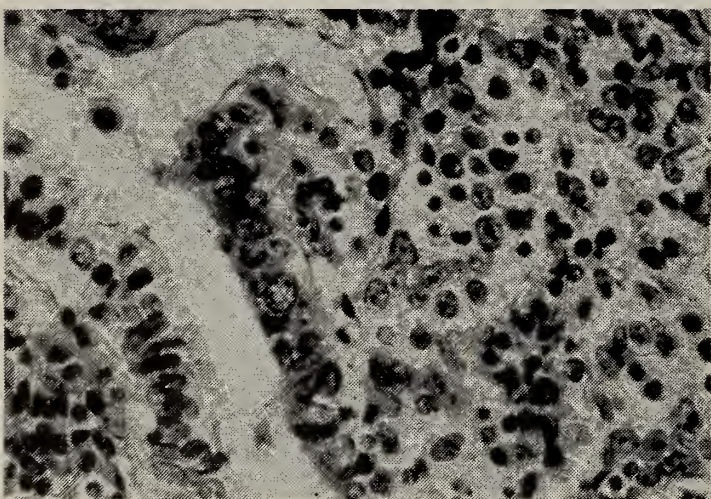


Fig. 3. Atypical nucleoli.



Fig. 4. Benign adjacent mucosa.

The Story Behind the Word

Some Interesting Origins of Medical Terms

Cachet—Coming from the French word “cacher” meaning “to hide,” this term is descriptively applied in pharmacy to a form of medication consisting of two rounded pieces of wafer which are pressed together at the edges so that its concavity encloses or hides an ill tasting medicine.

Calamine—A name applied to native zinc carbonate and also to prepared or official calamine, which is zinc oxide with a small amount of added ferric oxide. This term is of disputed origin but is commonly believed to be derived from the Latin word “calamus” or reed because zinc carbonate in the process of smelting adheres to the furnace in reed shaped crystals. However, the term is more probably the result of a corruption by the medieval alchemists of the Latin word “cadmia” and the Greek word “kadmia” which was the ancient name applied to zinc ores in general. These ores were so called because they were first found at the City of Cadmos in Thebes.

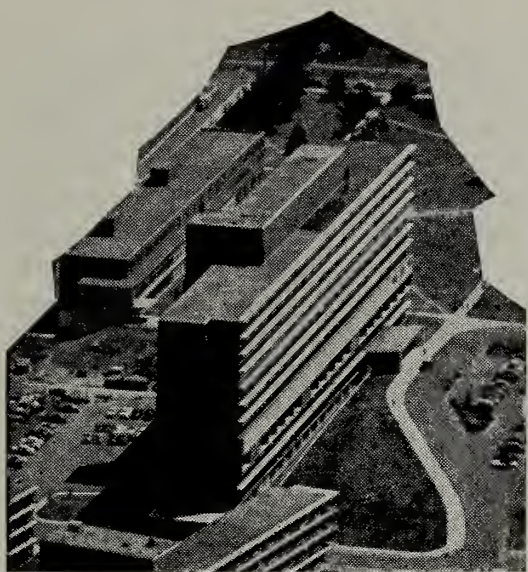
Calcaneus—Designating the heel bone, this term comes from the Latin word “calcaneum,” or heel. This in turn comes from the Latin word “calx” denoting chalk or limestone, and this bone was probably so named from its resemblance to a piece of limestone.

Calm—This word came into English via the French from the Latin word “calma,” which in turn came from the Greek word “kauma” meaning heat. At midday in ancient Athens the air was very hot and the shops closed and the workers rested and thus we get our idea of “calm” meaning a general rest and quiet.

Calomel—Coming from the Greek words “kalas” meaning fair or beautiful, plus “melas” or black, the name literally means the “beautiful black” substance. A number of explanations have been advanced to explain this name. The name may have originally been applied to the black sulphuret of mercury and later transferred to the white chloride of mercury. Another explanation is that because this white powder becomes darkened upon exposure to light it was named from this characteristic. A more fanciful tale relates that this name was given to this medicine by Sir Theodore Turquet de Mayeme in the early seventeenth century because it was prepared for him by his favorite negro servant.

Gamete—This term designates a germ cell, which can be either a sperm or an ovum. It was introduced by Gregor Mendal, the Austrian monk, who formulated the laws of heredity. The term was adopted from the Greek words “gamos,” or marriage, and “gamete,” a wife and “gametes,” a husband.

—HARRY WAIN, M. D., Mansfield, Ohio.



A Case Record

From The University Hospital,
Columbus, Ohio

Edited Under the Auspices of the Ohio Society of Pathologists

Philip Wasserman, M. D., President

Presented by H. E. LeFever, M. D., and Emmerich von Haam, M. D.

Edited by Dr. von Haam

PRESENTATION OF CASE

THIS 31 year old white female was admitted to University Hospital in 1951 with the complaints of severe headache, dizziness and vomiting of two months' duration and blurring of vision for six months. A diagnosis of right acoustic neuroma was made and the patient was operated upon. The tumor was found enclosing the right cranial nerves V to XII and nerves VII, VIII and IX had to be resected to remove the tumor. At surgery it was felt that a small portion of the tumor adherent to the capsule might not have been entirely resected.

The patient was readmitted 1 month later and a diagnosis of obstructive hydrocephalus due to edema of the cerebellum or due to an arachnoid cyst was made. Spinal tap and local drainage at the right suboccipital incision site was performed. Six months later an anastomosis of the right seventh to the eleventh cranial nerve was performed.

The patient did fairly well until early in 1954, when she was seven months pregnant and again had become ill with nausea, vomiting, weight loss and weakness of her left arm and leg. Five months later she again started to have bifrontal and vertical headaches and blurred vision. After a severe head cold her frontal headaches became worse, especially on arising in the morning, and were accompanied by a roaring noise on the right, paresthesia of the left arm and leg, blurred vision, occasional diplopia and continued nausea, vomiting and decreased appetite.

PHYSICAL EXAMINATION

The temperature was 98.4°F., pulse 96, respirations 16 and blood pressure 100/70. There was a well-healed surgical scar in the right posterior parietal area, the skin flap covering a bone defect in this area. The optic discs showed scarring and atrophy, most marked on the right. There

was scarring of the right cornea. The pupils were round, regular and equal and reacted to light and accommodation. There was bilateral nystagmus and papilledema.

There was atrophy of the right trapezius and rhomboid muscle and also a right Bell's palsy. The tongue protruded to the right and her palate was deviated to the left. No nuchal rigidity was noticeable. The heart showed normal sinus rhythm with no murmurs or enlargement. The lungs were clear.

On neurological examination the reflexes were decreased bilaterally, the visual fields were intact, and the third, fourth and sixth cranial nerves were normal except for horizontal nystagmus. There was partial loss of function of the ophthalmic division of the right fifth cranial nerve. There was right facial weakness and total right deafness. There was no response to labyrinthine stimulation. Babinski sign was negative.

LABORATORY FINDINGS

Cultures of the cerebrospinal fluid grew hemolytic staphylococci and *Pseudomonas aeruginosa*. The spinal fluid contained white blood cells varying from 3,000 to 27,000 with 6 to 90 per cent polymorphonuclear leukocytes and 10 to 84 per cent lymphocytes, with 380 mg. of protein. Liver function tests gave normal findings except for some reduction in total cholesterol. The blood urea nitrogen ranged between 10 and 13 mg. The electrolytes remained at normal levels.

HOSPITAL COURSE

Soon after admission a right ventriculostomy was done to remove fluid. Shortly following this she went into coma and remained during the rest of her hospital stay in a decerebrate state. An exploratory craniotomy was done and a plastic arachnoiditis was found. Because of the scarring of the right pupil a tarsorrhaphy was performed. At one time her prothrombin time was low, but

Submitted June 23, 1956.

she responded well to vitamin K therapy. Through most of her hospital course she was maintained on tube feeding. There were a few intermittent episodes of hematemesis. She expired on July 14, 1955, after a hospital stay of seven months.

CLINICAL DISCUSSION

DR. H. E. LEFEVER: Gentlemen, today we are dealing with a patient complaining of severe headache, dizziness and vomiting of some months' duration and on whom a diagnosis of right acoustic neurinoma was made some years ago. There is probably no neurological disease in which the chronological events are more typical than the signs and symptoms of a developing neurinoma.

This tumor, as you know, arises from the sheath of the eighth nerve within the internal auditory meatus and it would be logical to assume that one of the first symptoms would be those applying to a dysfunction of this nerve. Tinnitus is usually the first symptom that this produces. As this progresses there is a general decrease in the acuity of hearing, and then we observe explosive bouts of vertigo due to impingement upon this structure.

INVASION OF TUMOR

As the tumor begins to invade the other cranial nerves, the fifth and seventh nerves will be involved because of their rather close relationship to the eighth nerve, and later the ninth, tenth, eleventh, and even the twelfth nerves. Thereafter pressure signs may develop upon the cerebellum, which overlies the developing neoplasm. Then as the tumor enlarges mesially we begin to see evidence of an increase of the intracranial pressure.

Prior to this time all of the signs are strictly localizing, indicating first dysfunction of certain cranial nerves, then of the cerebellum, and finally, due to occlusion of the aqueduct and the fourth ventricle we observe choking of the disks and hydrocephalic vomiting. This is the sequence of events that transpires. Therefore acoustic neurinoma is a tumor that one should very easily diagnose if one is alert and does not consider every case of tinnitus, loss of hearing and vertigo as Menière's disease until it is too late.

At surgery a massive tumor was found encompassing the fifth to twelfth cranial nerves on the right, and the seventh, eighth and ninth nerves had to be resected in order to remove this mass. Very frequently it is impossible to save the seventh nerve and it must be sacrificed in order to effectively remove the tumor. The eighth nerve is invariably sacrificed. She was readmitted one month later with a diagnosis of hydrocephalus.

Following the removal of such a tumor it is very possible that an extensive degree of arachnoiditis with formation of arachnoidal cysts may develop, and particularly is that true in the event that there is not a meticulous closure of the

muscles in the completion of the operation. Often a small bit of arachnoid can herniate into the muscle plane and cause a tremendous accumulation of fluid, and in order to effectively correct this the neck of the arachnoidal cyst must be resected and the muscle closure must be complete. However, apparently spinal taps and local drainage at the right suboccipital incision corrected the situation satisfactorily.

Later an anastomosis of the seventh to the eleventh cranial nerves was done. In the beginning of the function of such an anastomosis it will be necessary to move the shoulder in order to effect movement of the face, but ultimately the movements will be dissociated so that the patient may move the face without being compelled to move the shoulder. However, there is no emotional component to the movement after such an anastomosis, and smiling or crying will be expressed entirely by the opposite side of the face, although no weakness is noted upon movement of the face, wrinkling the forehead or closing the eyes. Three years later the patient started again to have bifrontal and vertical headaches and blurred vision.

TUMOR'S LIFE HISTORY

I would like to discuss here the life history of this type of tumor. It was not until the twilight of the past century that these tumors were first attacked surgically. Ballance was among the first, in 1899, and by 1910 a sizable series had been operated upon, but the mortality rate was approximately 80 per cent. Then Cushing became interested in this problem and devoted all his time to the surgery of pituitary tumors, midline cerebellar tumors, and pontine angle tumors. He succeeded by meticulous technique in reducing the mortality rate to 11 per cent and the results became quite satisfactory. Then he noted that after 2½ to 5 years the acoustic nerve tumors tended to recur and that surgery had to be repeated sometimes as often as five times. We know now that unless the capsule is removed with the tumor there is great likelihood of its recurrence in anywhere from 2 to 5 years.

In 1924 Dandy first carried into effect the complete cure of this type of lesion with even a lower mortality rate than attended the partial removal. Once the tumor mass was removed he was able to grasp the capsule with the forceps and gradually tease the mesial portion away from the brain stem. It is true, in my opinion, that if the tumor is not completely removed, the blood supply, coming as it does for the most part from the transverse pontine vessels, will be sufficient to permit and actually promote further growth.

So it seems extremely likely that by 1954 this patient was beginning to get into the same trouble that she had in 1951. Then she got worse after a severe head cold. The roaring noises on the right are somewhat difficult to account for because of the fact that the eighth nerve was

completely destroyed during the first operation. However, the paresthesias upon the opposite side are rather common in that there is pressure upon the medial lemniscus and above the decussation, so that we may have contralateral paresthesias. Occasional diplopia, and of course almost invariably nystagmus, occur due to an encroachment upon the dentate nucleus of the cerebellum. The nausea and vomiting we could explain possibly from an increased intracranial pressure.

The physical examination showed scarring of the right cornea, probably due to the fact that she could not approximate the lids for a period of time because of her seventh nerve palsy. Drying of the cornea, ulceration, conjunctivitis and corneal scarring may result from this failure of the lids to close. There was a bilateral nystagmus and there was papilledema. I would venture the opinion that the patient had choking of the disks during her first illness and after it subsided it would leave a scarring of the disk or an optic atrophy. As the intracranial pressure reaccumulated a second papilledema developed, so that she had both atrophy and choked disk in both eyes. I can account very readily for the paralysis of the trapezius because she had sacrificed one eleventh nerve, but I do not see why the rhomboid muscle should have atrophied unless it was a disuse atrophy from not using the shoulder. From her Bell's palsy we can conclude that the nerve anastomosis was not a satisfactory one as far as function was concerned.

THE SPINAL FLUID

From the examination of the spinal fluid we can make the diagnosis of a purulent meningitis. I want to emphasize the fact that irrespective of the number of cells contained in the spinal fluid we are not justified in making the diagnosis of meningitis until we are able to demonstrate bacteria in the spinal fluid.

What was the treatment and the hospital course of this patient? The right ventriculostomy which was done to remove excess intraventricular fluid is a very valuable procedure when a patient is admitted with an increase of intracranial pressure. By inserting a drain into the ventricle we are able to control the pressure of these individuals and get them into a better state of fluid balance. We can leave the drain for a period of 8 to 10 days, during which time we can establish an electrolyte balance and get them into condition for a more formidable procedure of, say a craniotomy.

I had a case once where I thought I could safely tap the ventricle to remove the pressure produced by a posterior fossal lesion, and almost as the needle was in situ the patient went into a decerebrate state. We were removing a vis a tergo which we thought forced the brain structures through the aperture of the tentorium and caused herniation of the uncus. Why would we

then get into trouble? The reason for that is this: We forget that we may also have an enormous pressure confined to the posterior fossa and that a state of equilibrium could exist between the pressure above the tentorium and that below the tentorium. If we remove then the pressure above the tentorium the pressure below may cause a herniation upwards and produce damage to the brain stem with an irreversible decerebrate state.

Sir Hugh Cairns of London and Oxford was the first to call attention to this reverse herniation in the presence of a very high pressure within the posterior fossa, and therefore ventriculostomy cannot be regarded as a completely innocuous procedure. In this patient I would predict that something similar happened and that the posterior cerebral arteries and the basilar artery were damaged causing damage to the brain stem and a decerebrate state. Of course if simultaneously a needle would have been placed into the posterior fossa, this might have been averted. A damage to the brain stem between the red nucleus and the calamus scriptorius will produce a decerebrate state.

LAST EXPLORATION

At the last exploration an arachnoiditis was found, which we may well expect. Her intermittent episodes of hematemesis may suggest the development of neurogenic ulcers, a lesion which is especially prone to occur in a posterior fossal lesion. We have seen a complete dissolution of the esophagus and huge holes in the stomach develop within a very short time after a traumatic cerebral lesion, and we offer this as a possible explanation for her occasional hematemesis.

In summary, I should say therefore that this patient did not have a recurrence of her neurinoma but a continuum. It just continued to grow from a small remaining tumor rest. As a result of her head cold she developed a meningitis, and she died as a result of her meningitis, of her tumor and of an upward herniation through the inferior surface of the hiatus of the tentorium which impaired irreversibly the brain stem.

CLINICAL DIAGNOSIS

1. Acoustic neurinoma.
2. Acute meningitis.
3. Decerebrate state.

PATHOLOGIC DIAGNOSIS

1. Acoustic neurinoma.
2. Purulent and chronic arachnoiditis.
3. Acute and chronic hypophysitis.
4. Ulcerative esophagitis.
5. Bilateral bronchopneumonia.

PATHOLOGIC DISCUSSION

DR. EMMERICH VON HAAM: The patient was normally developed but markedly emaciated. Both ears showed marked decubital gangrene. There were bilateral corneal opacities and conjunctival

adhesions almost closed the right eye. There were also extensive decubiti on both buttocks, knees, heels, the sacrum and shoulder regions. The heart was small and brown. The bronchi contained pus. All parenchymatous organs were atrophic. The esophagus showed superficial ulcerations.

The skull showed an operative defect which was covered by a skin flap. In the right posterior and middle fossae the arachnoid membrane was markedly thickened and infiltrated with exudate. There was an accumulation of fluid forming a pseudocyst beneath the optic chiasm. Most of the right cerebellar hemisphere was missing. The right cerebellopontine angle contained a small grayish yellow tumor mass measuring 3 by 3 by 1 cm. Section of the brain showed an increase in the size of the ventricles. The right uncus and the right temporal lobe showed an indentation suggesting previous herniation. The brain stem appeared soft and swollen and an actual indentation was seen in the right side as a result of pressure. The right internal meatus of the petrous bone was widened and appeared eroded.

MICROSCOPIC EXAMINATION

Sections through the lungs showed a severe bronchitis with numerous foci of bronchopneumonia. Sections of the gastrointestinal tract showed superficial necrosis of the esophagus and severe atrophic gastritis. The pituitary was partially necrotic and surrounded by exudate. The kidneys showed a severe degree of tubular degeneration. Sections from the tumor showed a typical acoustic neurinoma. The membranes of the brain were acutely inflamed and showed marked fibrosis. Section through the brain showed moderate diffuse edema without any localized lesion.

AUTOPSY SUMMARY

From the autopsy I would like to summarize the case as follows: The patient's first tumor must have been large and the first operation necessitated excessive traumatization of the cerebellum with subsequent severe chronic arachnoiditis. The recurrence of the tumor from the cells left behind and the arachnoiditis both were responsible for the internal hydrocephalus which necessitated the terminal hospitalization of the patient. She died with a blood urea of 262 mg. and a creatinine of 3.4 mg. I consider the uremic condition not of renal origin but rather caused by starvation, septicemia and the prolonged agonal state.

The occasional hematemesis can be well explained by the findings of esophagitis and atrophic gastritis. The fact that her pituitary was involved in the inflammatory process explains the severe cachexia and the marked atrophy of all glands and parenchymatous organs. We could not demonstrate the sudden upward herniation which Dr. LeFever suggested as the cause of her decerebrate state, but we

do feel that her previous uncus herniation could still be demonstrated. The meningitis may well have originated from a severe sinusitis or the head cold, as was pointed out previously.

GENERAL DISCUSSION

MEDICAL STUDENT: How long can a patient live in such decerebrate state?

DR. LEFEVER: I have known a patient who was maintained in relatively good condition for seven years. This was a child and the mother devoted her entire life to his care. The decerebrate state must be considered irreversible and death usually comes due to a second complication such as malnutrition, decubital ulcers or infection.

DR. VON HAAM: Do patients in this condition show any evidence of a mental life? Do they dream or react?

DR. LEFEVER: The only reaction one can elicit from these patients is that they will move their arms and legs if you turn their heads.

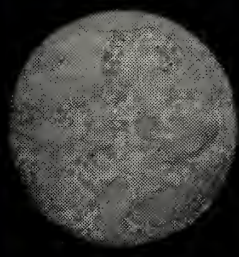
Effect of Cortisone on Experimental Pseudomonas Corneal Ulcers

Corneal ulcers due to *P. aeruginosa* have always been a constant source of apprehension to the ophthalmologist. Fortunately, however, we have at our disposal polymyxin B—an antibiotic which has been shown to be highly specific for many strains of *Pseudomonas*. Because of the increased use of cortisone and cortisone-antibiotic combinations in ocular inflammations, this study was instigated to determine the effect of cortisone on experimentally produced *Pseudomonas* corneal ulcers in rabbits.

The results obtained would indicate that cortisone may modify adversely the course of the infections, since the majority of rabbits receiving this steroid developed a severer corneal lesion than those not receiving cortisone. On the other hand, steroids given concurrently with polymyxin B did not seem to affect the beneficial action of the antibiotic. From this, it would appear that if cortisone is prescribed the effective antibiotic must also be prescribed.

Obviously, cortisone incorporated with a non-effective antibiotic would be no better therapeutically than the steroid alone. Thus the possibility would exist that the clinical course of the infectious corneal ulcer might be more devastating. It must be remembered, however, that different strains of *Pseudomonas* may vary in invasiveness.

These findings are in complete agreement with the statement by Thygeson and his co-workers that "great care should be exercised in the use of cortisone and hydrocortisone in central corneal ulcers and that bacteriologic diagnosis should be made prior to employment of these hormones."—Ted Suie, Ph.D., and Frank W. Taylor, M.D., Columbus: *A.M.A. Archives of Ophthalmology*, 55:53-56, July, 1956.



MATERNAL HEALTH IN OHIO

A CONTINUOUS state-wide Maternal Mortality Study is being conducted in Ohio by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health and assisted by official representatives of the various County Medical Societies of the state.

Since work of the committee is educational as well as statistical, summaries of some of the cases studied by the committee, based on anonymous data submitted, will be published in *The Ohio State Medical Journal* from time to time. Each presentation will be brief but informative. It will contain opinions of the committee, based on the data submitted for review. Three cases of maternal death due to hemorrhage are presented in this initial report.

The Committee on Maternal Health takes this opportunity to acknowledge with gratitude the excellent cooperation of all Ohio physicians, county chairmen and various others in the initiation and maintenance of this Maternal Mortality Study, covering the 88 counties of Ohio.

CASE NO. 77

This patient was a 41 year old, negress, primi-gravida who died undelivered. She had called her family physician and complained of marked pain in the upper abdomen and symptoms suggestive of recurrent cholecystitis. He sent her to the emergency room of the hospital for admission and diagnostic study.

On admission she gave a history of old pelvic inflammatory disease and said she was never pregnant. Her last menstrual period appeared about two weeks previously and was normal. Physical examination revealed a well developed and moderately obese woman complaining of upper abdominal pain; temperature 100°, pulse 112, respirations 28, blood pressure 140/90. The abdomen was prominent but not distended, and there was slight tenderness in the upper abdomen. Pelvic examination produced no symptoms of pain, but the exact size of the uterus could not be discerned because of patient's obesity. Hemoglobin was 10.4 Gm., hematocrit 31 per cent, leukocytes 14,500 with 84 per cent segmented cells and 5 per cent stab form neutrophils. Urinalysis not remarkable.

She was attended again by the surgeon on service at 9 p. m., was comfortable, and an intravenous infusion of 5 per cent glucose was administered. Nurses' records showed following notes:

	T	P	R	BP
4 p. m. _____	100	112	28	140/90
8 p. m. _____	99.6	84	24	
Midnight _____	99.2	84	20	
1 a. m. _____				92/56

About 1:00 a. m. on the next day, the night supervisor found the patient screaming, and thus disturbing other patients; she noted that the patient had received shock therapy in the past for alleged mental disease, and she called the patient's family to come sit with the patient. At about 3:30 a. m. the patient's cardiovascular sys-

tem apparently collapsed, and she died at 3:45 a. m. the same day.

Autopsy permission was obtained. However, prior to the postmortem examination, it was felt that the patient had had a cardiovascular accident (ruptured aneurism or pulmonary embolus). When the pathologist approached the peritoneum, he noted its blue tinge and ventured that the patient had probably ruptured an aneurism. When the abdomen was opened, the pelvis was examined and the diagnosis was obvious.

Pathological diagnosis: Massive hemoperitoneum (5,000-6,000 cc.) following spontaneous rupture of right ectopic pregnancy; old healed pelvic inflammatory disease with peritubal adhesions; adhesions between right leaf of diaphragm and liver; hypertrophy of the heart (460 Gm.) and interstitial edema and fragmentation of myocardium, were principal findings.

COMMENT

The report on this patient was received by the Committee with great interest, and members engaged in considerable discussion of its bizzare features consisting of atypical symptoms and signs. Members felt that (in retrospect) blood pressure readings recorded regularly at least every four hours (4 p. m. to 1 a. m., and thereafter) and more frequent abdominal examinations shortly after midnight, might have afforded a strong angle of suspicion towards the diagnosis. Based upon the information provided, the case was considered nonpreventable.

CASE NO. 20

This patient was a 26 year old, white, Para I, ab. I, who died 13 days, postabortal. The past

history was not remarkable; she had a previous term pregnancy delivered two years before, without complication. She registered in her second month of pregnancy. Her last menstrual period was October 12th; outside of mycotic vaginitis for the first three months, her prenatal course was normal, and prenatal care was adequate. Scanty but constant bleeding began the 17th week.

After four days she was admitted to the hospital, fever of 105°, and aborted the following day, with severe hemorrhage and a retained placenta, which was manually removed. Hemorrhage continued; four hours later the blood pressure was recorded at 70/0. Dilatation and curettage was performed, removing a small chunk of placenta, and the uterus and vagina were packed. Culture of the uterine cavity revealed *E. coli*. Bleeding continued, and consultation was obtained with a hematologist, who found the platelet count 17,000 per cubic mm. and made a diagnosis of idiopathic thrombocytopenic purpura.

In the next 24 hours the patient received 12 units of whole blood, 8 of which were fresh blood. Urinary output diminished to 25 cc. in this 24 hours, and was 50 cc. in the next 24 hours; transfusions were discontinued, and levophed® was administered. Oliguria persisted for eight days. When the patient developed respiratory difficulty, and an hematocrit of 58 per cent, multiple phlebotomies were performed, removing a total of 2,000 cc. of blood.

On February 28 the patient suffered dyspnea, with thick tracheobronchial secretions; a tracheotomy was performed. Electrolytes were administered; when the patient's jaws became set, toxin-antitoxin was administered. On March 3 there was sudden respiratory failure, and although the patient was placed in the respirator, her condition deteriorated, and she died that evening. Autopsy permission was granted. During the examination a culture of the uterine cavity was made, and was negative for tetanus.

Pathological diagnosis: severe purulent bronchitis and broncho-pneumonia, toxic splenitis, uremia (clinical), lower nephro-nephrosis (recovery stage), status postabortion 13 days, sub-acute endometritis and metritis, acute colitis, focal necrosis of the adrenals.

COMMENT

The members of the Committee discussed the various facts presented in this case, and voted it preventable, principally upon the basis of delay. It was felt that the curettage could have been performed more promptly to avoid blood loss during the four hours, and that continued bleeding through the vaginal-uterine packing following the dilatation and curettage might have led to the consideration of other (perhaps more radical) surgery, to stop the inevitable and constant blood loss.

From the case report, it would seem that 12 units of whole blood, administered in 24 hours, was excessive, and yet the Committee realized that the clinical appearance of the patient (which was not mentioned in the report) undoubtedly encouraged this heroic therapy.

CASE NO. 57

This patient was a 28 year old, white, Para 0, Ces. ii, who died about four hours postpartum (postoperative). The past history was not re-

markable. She had had one previous pregnancy uncomplicated, which went to term; after a long (trial of) labor she was subjected to a cesarean section (in another hospital) and a living baby which weighed over nine pounds, was delivered, following which she followed an uneventful course.

The patient consulted her family physician for prenatal care during the last pregnancy, and made 10 visits to his office; care was considered adequate, with an estimated date of confinement set for August 13th. Physical and laboratory findings during the prenatal period were not remarkable. Her blood type was A, Rh positive.

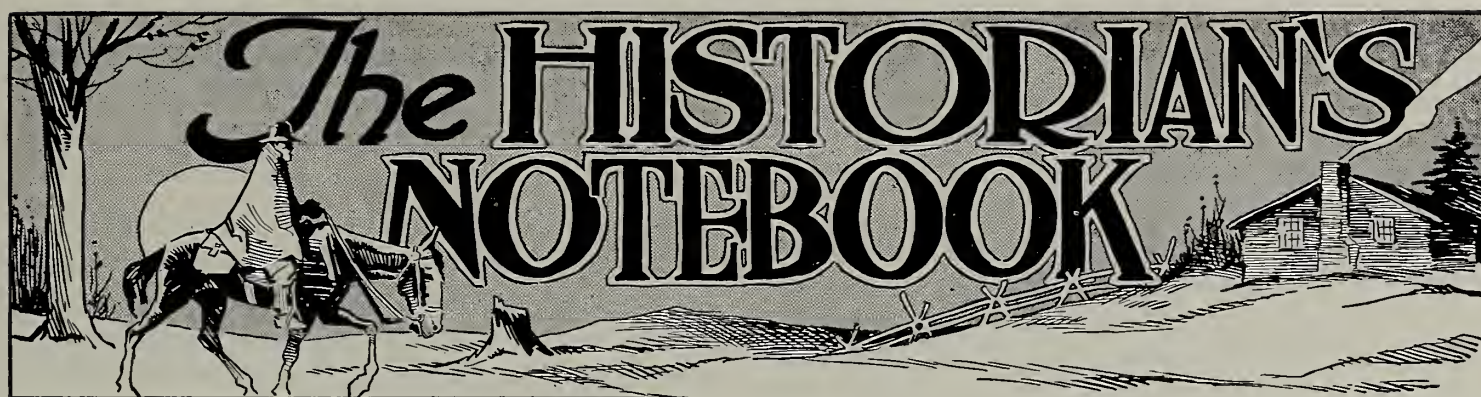
On June 8th and June 17th (approximately 30 weeks gestation) the patient experienced painless bleeding, was told she had a low placenta, and was further instructed to proceed to the hospital at once, if bleeding recurred. On July 1st she had profuse, painless, bleeding, pulse 100, blood pressure 110/70, and she was taken to the hospital immediately; within 20 minutes she was in the operating room and blood started. Laparotomy was performed; it was noted that a classical cesarean section had been contemplated, but upon observing the uterus, a hemorrhagic mass was seen beneath the uterovesical peritoneum. This further appeared to be placental tissue invading the wall of the previous incision, and with the scar, was excised. A living premature fetus was delivered (slightly over 3 pounds), in poor condition, and it died two days later.

As the operation continued, bleeding was profuse from the lower segment; it was controlled by packing and compression of uterine arteries. However, the patient went into shock, pulse 140 to 150. The uterus contracted down well, the bleeding is said to have been checked, so the incision was closed instead of doing a hysterectomy. With blood running through two cannulas, patient was returned to her room, but in spite of oxygen therapy, solu-cortef,® etc., the patient died four hours after her admission to the hospital, of "Irreversible shock"; 4 units of blood had been administered. There was no visible hemorrhage after the patient returned to her room. The pathologist reported decidual and large multinucleated giant cells in smooth muscle in the tissue submitted; these invaded the uterine wall, and represent placenta accreta. There was no autopsy.

Cause of death: Uterine hemorrhage, shock, with placenta previa, uterine pregnancy 30 weeks' gestation, placenta accreta.

COMMENT

The Committee voted this death nonpreventable. The accuracy of an early diagnosis, together with proper preinstruction of the patient, and her prompt arrival in the operating room after hemorrhage appeared, all merit commendation. However, some question is raised as to the judgment exercised during the procedure, in view of the massive hemorrhage encountered; no criticism could have been placed had the operator chosen to perform a hysterectomy. Quite obviously the diminution of bleeding which erroneously gave the impression of controlled hemorrhage, was actually a condition of shock. No mention was made of postoperative urinary output, and the question of renal failure, as a cause of death was discussed by the Committee.



Meetings of the Faculty of Starling Medical College in 1858

JONATHAN FORMAN, M. D.

IN THE MIDDLE of the last century medical college faculties consisted of six or seven physicians, a paid professor of chemistry, and a demonstrator of anatomy. This last position was not held by a voting member of the staff but by a younger physician who generally was responsible to the professor of anatomy.

The funds of the college were derived from the tuition fees. At the end of the year that which remained after repairs had been made and books for the library had been bought and the professor of chemistry paid for his services, was divided among the several professors. Under these circumstances faculty meetings took on many a controversy as to details, seldom as to policy. At the time the meetings, whose minutes are recorded here were being held, there was sharp controversy going on between the three schools in Ohio, each accusing the other of extending credit by means of promissory notes to its students and claiming this as unfair recruit and detrimental to the profession.—EDITOR.

Columbus, May 15, 1858.

"The Faculty of Starling Medical College met pursuant to adjournment. Present: Profs. Smith, Wormley, Hamilton, Dawson, Loving. Prof. Carter was absent on business known to himself. The minutes of the last meeting were read and adopted.

"It was suggested by Dr. Wormley that a set of rules and regulations for the government of the Demonstrator of Anatomy should be drawn up and appended to the rules and regulations for the government of the Faculty of Anatomy, and on motion by Dr. Hamilton it was agreed that such regulations should be drawn up and submitted to the Faculty for consideration at the next regular meeting.

"On motion by Dr. Hamilton it was agreed that the Dean be associated with Dr. Wormley as a Committee having for its duty the preparation of the regulations above named.

"By general agreement it was decided that the lectures of the coming term, 1858-59 shall commence on Wednesday the 20th of October next at 9 o'clock in the morning.

"The report of the Dean on financial affairs was then called for. The dean stated that he had found it impossible, for various reasons, to get his report ready, and asked for further time for its preparation. On motion by Dr. Loving, further time was granted but the Dean was requested to make all due diligence.

"Dr. Wormley stated that he had imported a fine electromagnetic apparatus of great utility as a means of illustration, with the expectation that the Faculty should purchase it from him for the use of the school. The cost of said apparatus was stated by Dr. Wormley to have been \$35.00. Dr. Wormley wished to know whether the Faculty should purchase said apparatus. On motion by Dr. Smith it was agreed that the College should purchase said apparatus of Dr. Wormley at the price above named, \$35.00, and that this sum shall be paid out of any funds in the hands of the Dean available for the purpose.

"There being no further business to transact, the Faculty adjourned, to meet on Saturday evening, May 29, at the office of Professor Hamilton at 8 o'clock.

"S. LOVING, Sec."

"Saturday Evening, May 29, 1858.

"The Faculty of Starling Medical College met pursuant to adjournment. Present: Profs. Dawson, Hamilton, Carter, Wormley and Loving. Prof. Smith absent on professional business.

"The report of the proceedings of the last meeting were read and adopted by unanimous consent.

"The Committee on rules and regulations for the government of the Demonstrator of Anatomy

made a report as instructed, and the report, after some discussion, was rejected as being unsuitable and the Committee directed to prepare another for the consideration of the Faculty by the next regular meeting, or as soon as possible thereafter.

"The report of the Dean on finances was then called for. The Dean stated that his report was not ready, owing to circumstances over which he had no control. On motion by Dr. Carter the Dean was allowed further time for perfecting his report.

"By agreement, Drs. Hamilton, Dawson, Smith and Loving were appointed delegates to the State Medical Society which is to meet on Tuesday next, June 1st, at Massillon.

"The Dean said he wished to send a few catalogs for distribution, and requested that the members of the Faculty who had attended the meeting would form themselves into a Committee for the purpose of obtaining as nearly as possible the names of all the physicians known to be members of the Society. On motion by Dr. Carter it was agreed that a Committee be appointed by the Dean for the purpose of obtaining a complete list of the names of all physicians of Illinois, Indiana, Kentucky, Tennessee, Missouri, Iowa, and Minnesota, and as many other states as possible. The Dean appointed Drs. Carter, Hamilton, and Wormley as a Committee for this purpose and requested that they would use all due diligence in the performance of their duty.

"There being no further business for transaction the Faculty, on motion by Dr. Wormley, adjourned, to meet Saturday evening June 12, at 8 o'clock at the offices of Drs. Carter and Loving.

"S. LOVING, Sec."

EDITORIAL NOTE: It is interesting to note the geographical area involved in the solicitation for new students. Of course the purpose of sending the catalogs to these doctors was to have them recommend the Starling Medical College to their apprentices.

"Monday Evening, August 2, 1858.

"The Faculty of Starling Medical College met pursuant to a call for a special meeting ordered by the Dean. Present: Drs. Dawson, Hamilton, Wormley, Carter and Loving.

"The first subject which was presented for consideration was the propriety of publishing an "Announcement" in addition to the annual catalog already issued.

"The subject was fully discussed and finally it was agreed that an announcement should be published in the form of a circular, and on motion by Dr. Wormley it was agreed that 1,000 copies should be issued and distributed.

"Several other subjects of minor importance

then were discussed and finally the Faculty adjourned, to meet at the office of Dr. Hamilton Saturday evening, August 14.

"S. LOVING, Sec."

Saturday Evening, August 21, 1858.

"There was no meeting of the Faculty at the last regular evening, owing to the absence of members. The Faculty met this evening at the office of Dr. Dawson, pursuant to a call for a special meeting.

"The first subject presented for consideration was the report of the Committee for obtaining names. This Committee made a partial report, stating that it had obtained over 500 names of physicians residing in the various parts of the state and was receiving additions to the number every day. The Chairman asked and obtained further time for the performance of the duty assigned to his Committee.

"On motion by Dr. Wormley a committee was appointed to ascertain whether anything can be done with regard to the completion of the Museum rooms and furnishing the same, and if so, whether it is best to attempt it at this time. The Committee was also ordered to report the estimate of the cost of completing the museum room. The Committee appointed was Dr. Wormley, Chmn., Dr. Hamilton, and Dr. Loving.

"The report of the committee on rules and regulations for the government of the demonstrator of anatomy was then called for. Not ready. Ordered to report at the next regular meeting.

"The report of the Dean on finances was then called for and the Dean stated that he would again be obliged to report that his report was not ready owing to the fact that he had been unable to effect a settlement with Dr. Smith, the former Dean. Dr. Smith had promised a settlement at an early date and as soon as he does so, the Dean will be able to make his report.

"Dr. Carter called attention to the order issued by the City Council with regard to the paving, curbing, and guttering of the East side of the 6th St. opposite the West side of the College lot. The execution of this order has been deferred from time to time by the college authorities from want of funds, but the time has come when they will not be allowed to defer it much longer and Dr. Carter thought some action should be taken in this matter. He further stated that if the Faculty or the Trustees would have the gutter made and the curbstones placed, he would have the sidewalks gravelled, to answer instead of paving, at his own expense. The subject was discussed, and on motion by Dr. Hamilton, Drs. Dawson and Wormley were appointed a Committee to take under advisement and make a report at the next regular meeting.

"There being no further business the Faculty adjourned, to meet at the room of Dr. Wormley

in the American Hotel Saturday evening, September 11, at 8 o'clock Pm.

"S. LOVING, Sec."

Saturday evening, September 11, 1858.

"The Faculty met pursuant to adjournment and to a special call ordered by the Dean.

"The report of the proceedings of the last meeting was read and approved.

"The Committee for obtaining names made another partial report, adding additional names to the list already obtained by its members. The partial report was accepted and the committee continued.

"It was moved by Dr. Hamilton that the book of names belonging to the Faculty be revised by the secretary and the list obtained from the committee whose report was accepted as above stated, be added thereto. Adopted.

"The report of the Committee on the museum was then called for. The Chmn. stated that owing to the inability of the committee to obtain estimates from carpenters, plasterers, & c.c., the report was not ready. The Committee asked and obtained further time for making out its report.

"The report of the committee on rules and regulations for the government of the demonstrator of anatomy was then called for. The Committee then made the following report which was adopted, ordered to be recorded, and the Secy. directed to furnish the demonstrator with a copy thereof:

RULES RELATING TO THE DEMONSTRATOR OF ANATOMY

"I. The Demonstrator of Anatomy shall be appointed and removed by the Professor of Anatomy by and with the advice and consent of the Faculty.

"II. It shall be the duty of the demonstrator of anatomy, under the superintendence of the professor of anatomy, to take charge of the Dissecting Room and appurtenances, to keep the whole in good order, as well in vacation as during the sessions of the college. He shall also furnish subjects for discussion for the class and shall, at the proper hours, superintend the dissecting. He shall also be prosector for the Professor of Anatomy.

"III. The Demonstrator of Anatomy shall furnish for use of the professor of Anatomy and for the use of the Professor of Surgery such subjects as may be required for demonstration in each of their departments, without charge.

"III. The Demonstrator of Anatomy shall pay all the expenses of the dissecting

room, the preparation of the subjects agreed upon, except the expense for fuel, which shall be paid by the Faculty.

"THEO. G. WORMLEY,

"JNO. DAWSON, Committee'

"After the adoption of these regulations the Committee was discharged.

"The report of the committee on paving was then called for and submitted. The Committee had ascertained that the cost of making the guttering and placing the kerb would be 48 cents per linear foot or \$98.00 in all. The report was adopted and on motion of Dr. Carter the Dean was instructed to contract with some responsible person on the most favorable terms for the College for the execution of this work. On motion by Dr. Hamilton the Committee on paving was discharged as having performed the duty assigned.

"On motion by Dr. Hamilton, Drs. Wormley and Loving were appointed a committee to ascertain the cost of furnishing the library rooms of the college in such style as will render them satisfactory and acceptable as a public dispensary.

"On motion by Dr. Wormley, Drs. Hamilton and Loving were appointed a committee to mature a plan for the establishment of a public dispensary at the college & under the direction of the Faculty.

"On motion by Dr. Hamilton Dr. Loving was added to the "committee on obtaining names of physicians."

"There being no further business for transaction, the Faculty adjourned, to meet at the office of Dr. Smith on Saturday, the 18th of September, at 8 o'clock Pm.

"S. LOVING, Sec."

Saturday, Oct. 7, 1858.

"The report of the Committee on the museum was called for, read, and adopted. The committee was continued and ordered to have the work done, to have the museum room put in proper order for the reception of cases for specimens.

"Dr Loving's estimates for carpenter's work necessary for the completion of said rooms were: - - -

"Estimates for putting in glass and painting were: - - -

"Mr. Miles' estimates for plastering were: - - -

"The report of the committee on the dispensary was then called for next. Loving's estimates for completing this work were \$262.00.

"The remainder of the report containing a plan of organization and other items, was read and discussed pro & con & rejected amid much confusion, & the Committee continued & ordered to report at some future meeting.

"The report of the Dean on finances was called for and submitted.

"S. LOVING, Sec."

A Report of the Franklin County Pelvic Cancer Delay Committee

DOES a diagnosis of pelvic cancer mean death? Those who believe so have a "defeatist attitude" which the physicians are trying to break down. After a year's study of 1194 such cases reported by Columbus hospitals since 1940 they have conclusive proof that pelvic cancer can be cured, particularly if detected in the early stages and treated properly.

After hearing an address by Dr. John Yeattes Howsan, of Philadelphia, in which he outlined the work of a "Pelvic Cancer Delay Committee" in that city, the Columbus Obstetric and Gynecologic Society decided to sponsor a similar committee. Dr. Howsan had reported a marked decrease in the "time delay factor" as a result of his committee's work. The Franklin County Pelvic Cancer Delay Committee has met regularly since its organization, monthly at the Columbus Health and Safety Center.

OBJECTIVES

1. Shortening of the time between first symptoms and the starting of proper treatment.
2. Analysis of this "time delay factor" to see if it is wholly dependent on the patient; or the patient, and in part, the physician.
3. Improvement of patient care.
4. The keeping abreast of the most modern techniques of treatment.
5. The passing along to others in the medical field the information obtained by the study of individual case histories.

In reviewing the cases of the Society's members as well as the cases of other private practitioners,

attention of all physicians is called to "Time lost." This effort is already facilitating more prompt treatment of new patients. The Committee has actual proof that as far as cancer of the uterus is concerned over 90 per cent of the cases can be cured if the patients and the referring physicians get adequate treatment started soon enough.

Analyses of the cases of cervical cancer reported by Columbus hospitals in the last 15 years show that cures—patient living at the end of a five-year period without evidence of cancer—run 96.29 per cent for those detected in the very early stage—Stage 0. When, however, cancer is allowed to progress into later stages, the percentage of cures drops to 81.4 per cent for Stage I, 56.5 per cent for Stage II, 28.6 per cent for Stage III, and 4.1 per cent for Stage IV.

Many patients literally commit suicide by ignoring symptoms which they themselves know are warning signs. The obvious course is the hardest to take because of the dread of knowing the diagnosis. In this particular field, given an early opportunity for treatment, the patient with cancer has as good a chance of cure as he has with any major disease. Fear of a diagnosis or of hospital costs is a false economy because the real cost comes if the disease becomes far advanced. Then, it requires lengthy hospitalization.

JOINT REPRESENTATION

Hospital representatives on the Franklin County Pelvic Cancer Delay Committee are Dr. John C. Ullery, University Hospital; Dr. Ben Jacoby,



This is a typical meeting of the Franklin County Pelvic Cancer Delay Committee showing some members of the committee and other representatives. Left to right: Dr. John C. Ullery, Dr. Zeph J. R. Hollenbeck, Dr. John H. Holzaepfel, Chairman, Dr. Fred C. Hapke, Dr. Robert Hallett, Dr. Richard Wenzel, Dr. Harry E. Ezell, Dr. Anthony Ruppertsberg, Jr., Dr. Francis Gallagher, Dr. Mel A. Davis.

White Cross; Dr. Harry Ezell, Mt. Carmel; Dr. Francis Gallagher, St. Ann's; and Dr. Anthony Ruppertsberg, Jr., Grant. Drs. Hollenbeck and Ezell act as co-directors of the Cancer Delay Committee. Dr. Mel Davis aids in the pathological diagnosis.

The committee meets with Dr. Ollie M. Goodloe, City Health Commissioner, for what has been described "a total community project." Proceedings have been published by *The Ohio State Medical Journal* and by the Columbus Academy of Medicine. There is abundant evidence that these reports are being read throughout the state and that they are beginning to improve the care of pelvic cancer patients outside of Columbus.

The Delay Committee strongly recommends periodic health examinations every six months and that the cancer screening smear test be carried out at that time. It is a totally painless procedure which can be carried out in any physician's office and is of great assistance in the early detection of cancer.

Section Officers; Contact Them About Program Participation

In the very near future officers of the various Scientific Sections of the Association will begin formulating programs for the section meetings at the 1957 Annual Meeting of the Ohio State Medical Association in Columbus, May 14, 15, 16.

Members of the Association who may desire to be considered for a talk or discussion before one of the sections should get in touch with the chairman or secretary of the section.

The names and addresses of the section officers are as follows:

SECTION ON ANESTHESIOLOGY

Chairman, A. William Friend, 515 Nome Avenue, Akron 20; Secretary, John P. Garvin, 1077 East Livingston Ave., Columbus 5.

SECTION ON GENERAL PRACTICE OF MEDICINE

Chairman, Edwin Wm. Burnes, 301 North Washington St., Van Wert; Secretary, Raymond M. Kahn, 1523 West Riverview Ave., Dayton, 7.

SECTION ON INTERNAL MEDICINE

Chairman, J. Harold Kotte, 2328 Auburn Ave., Cincinnati 19; Secretary, John D. Battle, Jr., 2020 East 93rd St., Cleveland 6.

SECTION ON NERVOUS AND MENTAL DISEASES

Chairman, Arthur T. Hopwood, Cambridge State Hospital, Cambridge; Secretary, Robert B. Stevenson, Columbus Receiving Hospital, Columbus 10.

SECTION ON NEUROLOGICAL SURGERY

Chairman, Max T. Schnitker, 1031 Secor Hotel Bldg., Toledo 4; Secretary, William A. Nosik, 10515 Carnegie Ave., Cleveland 6.

(Continued in Next Column)

Nonprofit Hospital Not Immune From Liability, Court Holds

A corporation not-for-profit, which has as its purpose the maintenance and operation of a hospital is responsible for the torts of its employees under the doctrine of respondeat superior, the Ohio Supreme Court held in an opinion rendered on July 18, 1956.

The opinion in the case of *Avellone v. St. John's Hospital*, appealed from Cuyahoga County, overrules previous opinions of many years standing which had held that the nonprofit hospital is immune from damages in matters involving the care of patients by employees unless proved that the hospital was negligent in the selection of such employee or employees.

Text of the opinion, written by Judge Matthias and supported by four other judges, appeared in full in the July 23, 1956, issue of the *Ohio Bar*.

(Section Officers—Continued)

SECTION ON OBSTETRICS AND GYNECOLOGY

Chairman, Rollis R. Miller, 3031 Market St., Youngstown 5; Secretary, Harry T. Atkins, 401 Park Ave., Hamilton.

SECTION ON OPHTHALMOLOGY

Chairman, E. J. Wenaas, 710 Dollar Bank Bldg., Youngstown 3; Secretary, Roscoe Kennedy, 2020 East 93rd St., Cleveland 6.

SECTION ON OTORHINOLARYNGOLOGY

Chairman, Robert E. Boswell, 211 South Main St., Dayton 2; Secretary, William C. Thornell, 2508 Auburn Ave., Cincinnati 19.

SECTION ON PEDIATRICS

Chairman, F. Eugene Roach, 14805 Detroit Ave., Lakewood 7; Secretary, Miner W. Seymour, 375 East Town St., Columbus 15.

SECTION ON PHYSICAL MEDICINE

Chairman, Keith C. Keeler, 326 Locust St., Akron 2; Secretary, Ralph E. Worden, University Hospital, Columbus 10.

SECTION ON RADIOLOGY

Chairman, Frank A. Riebel, 15 West Goodale St., Columbus 8; Secretary, George F. Jones, Lancaster Memorial Hospital, Lancaster.

SECTION ON SURGERY

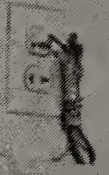
Chairman, James A. Helmsworth, 3231 Burnet Ave., Cincinnati 29; Secretary, Edwin H. Ellison, University Hospital, Columbus 10.

SECTION ON UROLOGY

Chairman, Robert A. Keating, 350 East Broad St., Columbus 15; Secretary, Richard S. Graves, 970 Reibold Bldg., Dayton 2.

MAPS

THE WORLD



ACHRON



ACHROMYCIN*

Tetracycline Lederle

in the treatment of

respiratory infections

January and his associates¹ have written on the use of tetracycline (ACHROMYCIN) to treat 118 patients having various infections, most of them respiratory, including acute pharyngitis and tonsillitis, otitis media, sinusitis, acute and chronic bronchitis, asthmatic bronchitis, bronchiectasis, bronchial pneumonia, and lobar pneumonia. Response was judged good or satisfactory in more than 84% of the total cases.

Each month there are more and more reports like this in the literature, documenting the great worth and versatility of ACHROMYCIN. This antibiotic is unsurpassed in range of effectiveness. It provides rapid penetration, prompt control. Side effects, if any, are usually negligible.

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ACHROMYCIN SF

ACHROMYCIN with STRESS FORMULA VITAMINS. Attacks the infection—defends the patient—hastens normal recovery. For severe or prolonged illness. Stress formula as suggested by the National Research Council. Offered in Capsules of 250 mg. and in an Oral Suspension, 125 mg. per 5 cc. teaspoonful.



For more rapid and complete absorption.
Offered only by Lederle!

dry-filled sealed capsules

¹January, H. L. et al: Clinical experience with tetracycline. *Antibiotics Annual* 1954-55, p. 625.



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AMERICAN CYANAMID COMPANY
PEARL RIVER, NEW YORK

*REG. U. S. PAT. OFF.

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Are You Eligible To Vote? . . .

September 26 Is a Vital Date for Those Who Must Register Before They Can Cast Their Ballots in the November 6 General Election

THAT all-important General Election is coming—November 6. But to some Ohio physicians and to many members of their families and friends, September 26 is an equally important date. That is the last day for registration for those who must register before they are eligible to vote.

Registration is a simple matter. Here are the points to be remembered, presented in question and answer form from information furnished *The Journal* by Secretary of State Ted W. Brown:

What is the registration deadline?

Forty days before the General Election, or September 26.

Who must register?

Every citizen who resides in a "registration district" must be registered with his county Board of Elections before he is eligible to vote.

What is a registration district?

The county Board of Elections must maintain a registration of eligible voters in every city of 16,000 population or over. Municipalities of less than 16,000 population may elect to maintain registration. The Board of Elections of a county may require registration in the entire county or in certain precincts. A registration district, therefore, may be a county, a municipality, a group of precincts or a single precinct.

How does a person know whether he is in a registration district or in a non-registration area?

If he resides in a municipality of 16,000 population or over, he must be registered. If he resides in a suburban community, a small municipality or a rural area, and is in doubt, he should phone the county Board of Elections and ask.

Under what conditions must a person re-register?

Registration is permanent, subject to the following exceptions:

a. If the citizen has not voted in a general, primary or special election since January 1, 1954, he must register again.

b. If the citizen has changed name—e. g., if a woman has married—she must re-register. If a woman marries between September 26 and November 6 she may vote on November 6 under her former name.

c. A veteran of the armed services must register after he is discharged.

d. A voter who changes his place of residence from one county to another, must register with

the Board in the county to which he moves if his new residence is in a registration precinct. A voter who changes his residence to a new address within a registration district must notify his Board of Elections of such change. Some boards require the voter to present himself in person; others accept written notice.

What is the procedure for voters in non-registration areas?

In precincts not in registration districts, citizens are automatically eligible to vote. A voter may be required at the polling booth to produce evidence to the satisfaction of the election judge, or under oath, that he is qualified to vote.

What is the residence requirement for registration?

A person who will have met the residence requirement for voting by November 6—that is, will have lived in the State one year, in the county and precinct 40 days, and is otherwise qualified to vote—may register on or before September 26.

If he has moved his residence between September 26 and Election Day, what can he do?

Vote at the precinct from which he moved.

If a citizen has moved or is planning to move prior to September 26, may he vote at the precinct in which he formerly resided?

No. If he does not qualify himself to vote in the new precinct by notifying the Board of change of address, he will have lost his privilege of voting on November 6.

Suppose he moves his residence on September 25?

He will have been in the new precinct for 40 days by Election Day and, therefore, may register immediately.

If a citizen in a registration district will reach his 21st birthday between September 26 and November 6, may he register?

Yes. He may register on or before September 26.

If a person who resides in a non-registration area will be 21 years old on or before November 6, what is the procedure?

If he meets other requirements of a voter, he will automatically become eligible to vote.

Where does one register?

At the headquarters of the Board of Elections

of county of residence or at polling places indicated by the Board.

Where does a student register?

In the county in which he maintained residence just prior to entering the institution of learning.

How does a disabled person register?

A voter who is prevented by sickness or physical disability from registering in person may apply to his county Board of Elections by mail or phone for registration forms. The application must state the facts as to the voter's disability. Both the registration forms and a declaration of

An educational and informative pamphlet, "1956 Voter's Guide" has been prepared and distributed by Secretary of State Ted W. Brown in collaboration with the American Heritage Foundation. Distribution has been made to Boards of Elections and to many civic organizations, and additional copies for distribution may be obtained from the Secretary of State as long as the supply lasts. The leaflet contains detailed information on registering and voting and is entirely nonpartisan.

the facts as to disability must be notarized, and both must be delivered to the Board of Elections by a reliable and responsible person. Some boards require this person to be a notary public.

What about persons in the armed forces?

Persons who are residents of a registration district and who are in active service in the armed forces, and are otherwise qualified to vote, may cast absentee ballots without previous registration.

Does this privilege extend to civilians who will be away from home on November 6?

No. Students and other persons who must be registered in order to vote and who plan to be away on November 6, should register now so that they will be eligible to cast absentee ballots.

ABSENTEE VOTING

Persons who will be away from home on November 6 should plan to cast absentee votes. Here are some dates to remember and other data on absentee voting:

Civilians who wish to cast absentee ballots must be qualified to vote the same as though they were voting at home; e. g., they must be registered if they live within a registration area.

Civilians must apply for ballots on forms furnished by election boards. Upon receipt of filled out applications, boards will mail ballots which

are to be properly filled out and returned in accompanying "identification" envelopes.

Ohioans who will be more than 10 miles from their polling places and outside their home counties on election day are eligible for absentee voter ballots.

September 7—First day for civilians outside the continental limits of the United States, such as wives of military men, to apply for absent voter ballots.

September 26—Last day for persons who must register in order to qualify for voting, to register with their local Board of Elections.

October 7—First day for absent and disabled voters within the United States to apply for ballots.

November 1—Last day for "absent or disabled" civilians to apply. The deadline is 4 p. m.

November 2—Last day for civilians to return voted ballots to election boards to have them count. The deadline is noon of that day. Military personnel have until noon of election day, November 6.

November 3—Last day for members of the armed services to apply for ballots. Their deadline is 12 noon. Military service personnel have been eligible to apply for ballots since January 1.

Court Says "Injury" in W. C. Law Must Be Result of Sudden Mishap

In the case of *Dripps v. the Industrial Commission*, the Ohio Supreme Court disposed of the case with the following important opinion:

1. The term, "injury," as used in the Ohio Workmen's Compensation Act, comprehends a physical or traumatic damage or harm accidental in character and as a result of external and accidental means in the sense of being the result of a sudden mishap, occurring by chance, unexpectedly and not in the usual course of events, at a particular time and place.

2. The fact that a workman is injured by exerting more effort or being subjected to a greater strain than is customary in the performance of his work is not in and of itself sufficient to entitle such workman to participate in the State Insurance Fund; and before such participation may be had it must appear that such increased effort or strain was occasioned by some sudden mishap or unusual event.

Courses on Diseases of Chest

The Council on Postgraduate Education of the American College of Chest Physicians will sponsor the following postgraduate courses this fall: 11th annual postgraduate course, Chicago, Hotel Knickerbocker, October 15-19. and the 9th annual postgraduate course, New York City, Park-Sheraton Hotel, November 12-16. Further information may be obtained from the College at 112 East Chestnut St., Chicago 11, Ill.

Fall Postgraduate Courses . . .

Excellent Array of Programs Has Been Arranged by District Societies And Other Organizations; Doctors Have Good Choice of Subject Matter

DISTRICT meetings of physicians has long been a custom in areas of Ohio and this custom is being continued this Fall with some excellent programs arranged for doctors. These programs are within easy reach for physicians in their respective areas. With the Fall also come many local meetings that have taken on special significance because of the special programs arranged.

Physicians will find, not only an opportunity to meet with their colleagues in the area, but will gain much current information on medical topics. Some excellent speakers and timely topics are listed.

Additional information on these and other programs will be published in subsequent issues of *The Journal*. Following are programs announced before this issue went to press:

September 19-20—Ohio Academy of General Practice, Annual Scientific Session, Columbus.

October 2—Muskingum County Medical Society Special Program, Zanesville.

October 3—Cancer Symposium, Dayton.

October 17—Northwestern Ohio Medical Association, Bowling Green.

October 18—Eighth Councilor District Meeting, McConnelsville.

October 18—Ninth Councilor District Meeting, Ironton.

October 24—Sixth Councilor Postgraduate Day, Youngstown.

* * *

Ohio Academy of General Practice, Columbus, September 19, 20

The Sixth Annual Scientific Assembly of the Ohio Academy of General Practice will be held on Wednesday and Thursday, September 19 and 20. All scientific sessions and exhibits will be in the new Franklin County Veterans Memorial Auditorium, across the bridge from the downtown Civic Center of Columbus and within walking distance of downtown hotels.

The Banquet, preceded by a social hour, will be in the Ball Room of the Deshler-Hilton Hotel. The program has been announced as follows:

WEDNESDAY, SEPTEMBER 19

(All time, Eastern Standard)

8:00 A. M. —Registration and Visit Exhibits.

8:45 A. M. —Opening of Annual Scientific Assembly.

9:00 A. M. —**H a z a r d s in Anesthesia**—Jay Jacoby, M.D., Columbus.

9:30 A. M. —**Principles of Electrolyte Therapy**—Willard E. Hauser, M.D., Cleveland.

10:00 A. M. —**Trends in Pediatric, Adult and Geriatric Nutrition**—Thaddeus D. Labecki, M.D., Jackson, Miss.

10:30 A. M. —Visit Exhibits.

11:00 A. M. —**Venous Thrombosis and Trypsin**—Bert Seligman, M.D., Toledo.

11:30 A. M. —**Evaluation of the Newer Types of Insulin**—Thomas G. Skillman, M.D., Cincinnati.

12:00 M. —Informal Buffet Luncheon. Visit Exhibits.

1:30 P. M. —**Herniated Lumbar Intervertebral Disk Problem**—H. R. Oberhill, M.D., Chicago.

2:00 P. M. —**Abnormal Uterine Bleeding**—Frederick H. Falls, M.D., Chicago.

2:30 P. M. —**Osteoarthritis**—Joseph E. Levinson, M.D., Cincinnati.

3:00 P. M. —Visit Exhibits.

3:30 P. M. —**Management of Congestive Heart Failure**—Hugh Luckey, M.D., New York City.

4:00 P. M. —**Cancer Detection in the Office of the Generalist**—John S. DeTar, M.D., Milan, Michigan.

4:30 P. M. —Visit Exhibits.

6:30 P. M. —Social Hour and Banquet, Deshler-Hilton Hotel, Ball Room. Address: **The Way To Win**—Major Norman Imrie, Columbus, educator-editor-entertainer.

THURSDAY, SEPTEMBER 20

8:00 A. M. —Registration and Visit Exhibits.

9:00 A. M. —**The Investigation and Treatment of Recurring Urinary Infections**—William J. Engel, M.D., Cleveland.

9:30 A. M. —**Ultrasonics in Medicine**—Herman J. Bearzy, M.D., Dayton.

10:30 A. M. —Visit Exhibits.

11:00 A. M. —**Office Management of Leukorrheas**—L. V. Dill, M.D., Washington, D. C.

11:30 A. M. —**Treatment and Prevention of Lateral Rotation of Legs and Flatfeet in Small Children**—J. H. Kite, M.D., Atlanta, Georgia.

12:00 M. —Informal Buffet Luncheon (South Exhibition Hall). Visit Exhibits.

1:30 P. M. —**Psychotherapy in General Practice**—Vernon P. Williams, M.D., Boston.

2:00 P. M. —**Hypnosis for the General Practitioner**—Seymour Herschman, M.D., Chicago.

(Continued on Next Page)

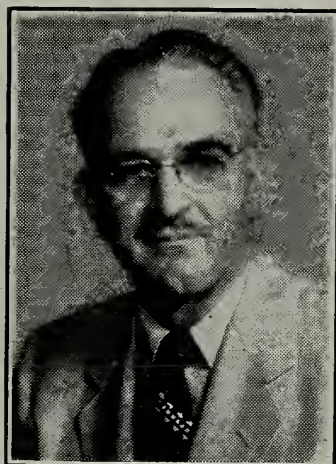
- 3:00 P. M. —Visit Exhibits.
 3:30 P. M. —Indications for the Ultimate Results of Splenectomy; A Twenty-Five Year Follow-Up Study—Charles A. Doan, M.D., Columbus.
 4:00 P. M. —Premalignant Lesions of the Rectum and Colon—C. W. Mayo, M.D., Rochester, Minnesota.
 4:30 P. M. —Adjournment.

* * *

Muskingum Society To Present Guest Orthopedic Surgeon at Meeting In Zanesville, Oct. 2

A nationally known authority on the "low back" will be guest of the Muskingum County Academy of Medicine on Tuesday, October 2.

He is Dr. Paul C. Williams, clinical professor of orthopedic surgery at Southwestern Medical



DR. WILLIAMS

College, Dallas, Texas, who will discuss his favorite subject. The meeting will begin with dinner at the Zanesville Country Club, about two miles north of Zanesville on Route 77, at 6:30 p. m.

Members of the medical profession in neighboring counties are invited to attend this special program, Dr. Lester Lasky, program chairman, announced.

A native of Ohio, Dr. Williams is a graduate of the University of Michigan Medical School, 1928, and did intern and residency work in Michigan. He has been on the orthopedic staff of Southwestern College since 1930 and was certified by the American Board of Orthopedic Surgery in 1936. Professional organizations in which he is active include the American Association of Orthopedic Surgeons and others.

* * *

Third Annual Cancer Symposium To Be Held in Dayton

The Montgomery County Medical Society and the Montgomery County Society for Cancer Control are jointly sponsoring the third annual cancer symposium on Wednesday, October 3, in the Biltmore Hotel, Dayton.

General practitioners will be interested in the announcement of the Education Committee of the Ohio Academy of General Practice: This program merits 4 hours of Category II credit.

Sessions are opened to all OSMA members. There will be no registration fee.

The program has been announced as follows:
 2:30 - 3:55 p. m.—Panel Discussions:

1. **Chemotherapy in the Management of Neoplastic Diseases**—Drs. B. K. Wiseman, Ohio State University; John Tuohy,

National Cancer Institute, and Robert Zipf, moderator.

2. **Cancer of the Mouth**—Drs. C. L. Ash, Ontario Cancer Institute; Harold Workey, Ontario Cancer Institute, and J. G. Tye, moderator.

3. **Malignancies of the Upper Gastrointestinal Tract, Pancreas and Biliary System**—Drs. Stanley Hoerr, Cleveland Clinic; Stuart Arhelger, University of Minnesota, and S. N. Maimon, moderator.

4:00 - 5:30—Panel Discussions (repeat of the foregoing panels so that physicians may attend two full sessions).

5:30 - 6:30—Social Hour.

6:30—Banquet

7:45—**The Psychological Impact of Cancer and Its Therapy**—Dr. Arthur M. Sutherland, Memorial Center, New York.

* * *

Northwestern Ohio Physicians To Meet In Bowling Green, October 17

The Northwestern Ohio Medical Association will hold its annual meeting in Bowling Green on Wednesday, October 17, Dr. Henry B. Larzelere, Toledo, president of the organization, announced.

This is one of the traditional meetings of Ohio and is backed by an organization whose history goes back many generations. This will be its 112th scientific assembly. The association comprises physicians of the Third and Fourth Councilor Districts.

Details of the program had not been completed as this issue went to press. The program will be announced later.

Taking an active part in the meeting will be Dr. James R. Jarvis, Van Wert, Councilor of the Third District, and Dr. Paul F. Orr, Perrysburg, Councilor of the Fourth District.

Members of the Ohio Academy of General Practice are authorized six Category I credit hours for this meeting.

* * *

Ironton To Be Scene of Ninth District Meeting on Thursday, October 18

The Lawrence County Medical Society will be host to physicians of the Ninth District with a program in Ironton, on Thursday, October 18. This is the first of such meetings in the district in several years, and officers are going all out to make it a successful one.

Key program speaker for the occasion will be Dr. William G. Myers, research professor of medical biophysics and director of the Division of Medical Physics and Radioisotopes at Ohio State University College of Medicine. Dr. Myers, in addition to being a doctor of medicine, holds the degree of Ph. D. in physical chemistry. His background in nuclear fission gave him a prominent part in the early atomic explosion tests in the Pacific, and he has studied extensively medi-

cal aspects of the atomic age under the Army medical program.

Dr. Myers will discuss "Medicine in the Atomic Age." Arrangements were under way as this issue went to press for a second speaker, whose name will be announced later.

Registration will begin at 1:00 p.m. in the MacArthur Hotel on Route 52, Ironton. The program will begin at 2:00 p.m. A social hour will be followed by dinner at 6:00 p.m.

After-dinner speaker will be George H. Saville, Columbus, public relations director for the Ohio State Medical Association, who will discuss the subject, "You and Your Public."

The program is being planned by Dr. Harry Nenni, president, and Dr. George N. Spears, secretary, and other members of the local committee. Plans are being made for a program for Auxiliary members.

Dr. C. L. Pitcher, Portsmouth, Councilor of the Ninth District, will play a prominent role in the meeting.

All physicians of the area and their wives are invited to attend this meeting. A nominal charge will be made to cover cost of dinner.

* * *

Eighth District Meeting To Be Held At Rocky Glen, October 18

A custom of long standing will be followed this year when physicians of the Eighth District meet for a program at Rocky Glen Sanatorium in McConnelsville, on Thursday, October 18. All physicians of the area are invited.

A special feature of the meeting will be a tribute to Dr. Edgar C. Jones, colonel, U. S. Army, retired, native of Morgan County who returned to McConnelsville in 1945 after 37 years of service in Medical Corps. Dr. Jones will receive the 50-Year Pin and Certificate of the Ohio State Medical Association.

Refreshments and a buffet style repast will follow the program.

Officers of the Eighth District organization are Dr. A. M. Kelley, president, and Dr. C. R. Reed, secretary, both of Lancaster. Dr. W. D. Monger, also of Lancaster, is Eighth District Councilor.

* * *

Sixth District Postgraduate Day Youngstown, October 24

Plans for the Annual Sixth Councilor District Meeting to be held this year in Youngstown, have been announced, and all indications point to a highly successful event. The meeting is scheduled for Wednesday, October 24, in the Stambaugh Auditorium.

Selection of the Auditorium for this year's meeting will provide much more adequate facilities for both members and exhibitors, including larger parking area, modern sound and visual equipment, with lunch available on the premises.

The banquet will be held in the evening at the Pick-Ohio Hotel.

An interesting and unusual selection of speakers has been obtained to make for a stimulating and informative meeting. This will include a special panel of experts from Loyola University for the Section of Obstetrics and Gynecology.

The Woman's Auxiliary will hold their sixth district meeting at the same time, with a luncheon at the Mural Room for members. All wives who are not active members are cordially invited and urged to attend. Interesting entertainment, as well as a cocktail party for the ladies, will be provided to make it an enjoyable day for the wives.

Highlighting the banquet in the evening, for members and their wives will be the speaker, Dr. Douglas Bond, of Western Reserve University, who will give his own refreshing views on how a psychiatrist sees the practicing physician.

As is customary, there will be morning and afternoon sessions, followed by the banquet and after-dinner address.

The following subjects and speakers have been announced:

Recent Advances in Treatment of Leukemia and Lymphomas, Dr. Frank H. Bethel, professor of internal medicine, University of Michigan, Ann Arbor.

Dr. Robert J. Coffey, professor of surgery, Georgetown University School of Medicine, Washington, D. C.

Dr. Chester Gajewski, clinical instructor, Department of Obstetrics and Gynecology, Stritch School of Medicine of Loyola University, Chicago.

Newer Aspects of Virology, Dr. Eli Gold, Department of Pediatrics and Contagious Diseases, City Hospital, Cleveland.

Glomerulo Nephritis and Nephrosis, Dr. Malcolm Halliday, assistant professor in pediatrics, Children's Hospital, Pittsburgh, Pa.

Fluid Balance, Dr. William S. Hoffman, lecturer in medicine, University of Illinois College of Medicine, Chicago.

Dr. John Isaacs, clinical assistant, Department of Obstetrics and Gynecology, Stritch School of Medicine, Loyola University.

Inborn Errors of Metabolism, Dr. Robert Klein, associate professor in pediatrics, Children's Hospital, Pittsburgh, Pa.

Etiological and Embryological Approach to Therapy of Cryptorchidism, Dr. C. Everett Koop, surgeon-in-chief, Children's Hospital, Philadelphia, Pa.

Cause, Treatment and Prophylaxis of Athletic Injuries, Dr. Aaron L. Lictman, professor of surgery, New York Polyclinic Hospital and Medical School, New York City.

Diagnosis and Treatment of Tumors of the Thyroid, Dr. Anthony V. Partipilo, associate

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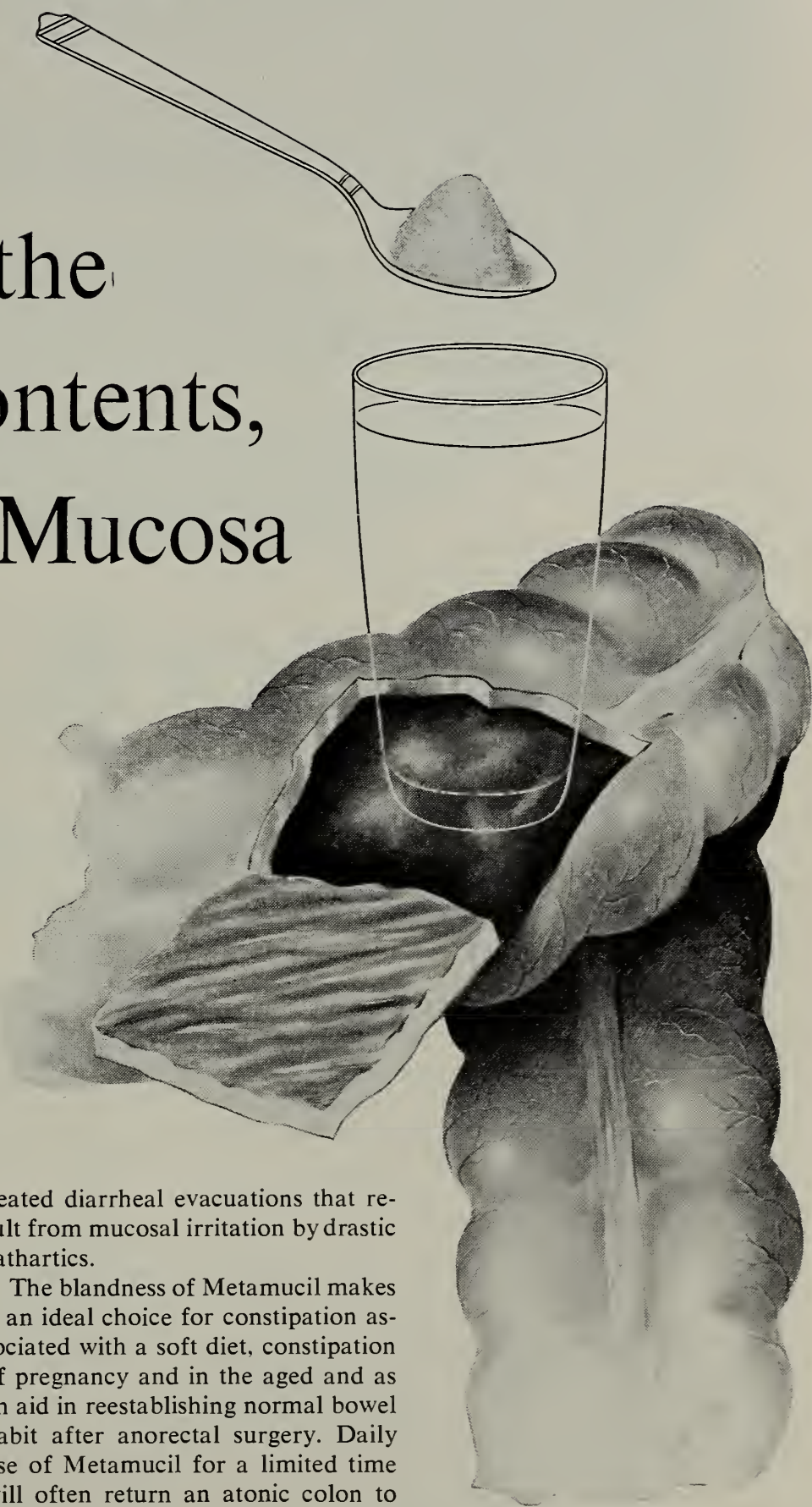
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clinical professor, University of Illinois, School of Medicine, Chicago.

Dr. Robert Priest, Department of Gastroenterology, Henry Ford Hospital, Detroit, Mich.

Dr. Herbert E. Schmitz, professor and chairman, Department of Obstetrics and Gynecology, Stritch School of Medicine of Loyola University, Chicago.

Chronic Pulmonary Emphysema, Dr. Maurice S. Segal, Clinical professor of medicine, Tufts School of Medicine, Boston, Mass.

Dr. Charles J. Smith, clinical professor, Department of Obstetrics and Gynecology, Stritch School of Medicine, Loyola University.

Common Endocrine Problems in Pediatrics, Dr. Samuel Spector, professor of pediatrics, Western Reserve University School of Medicine, Cleveland.

Hemorrhagic Disorders, Dr. Mario Stefanini, director of research, St. Elizabeth Hospital, Brighton, Mass.

Dr. Emmerich von Haam, professor of pathology, Ohio State University College of Medicine, Columbus.

The Psychiatrist Looks at His Fellow Physician, Dr. Douglas Bond, professor of psychiatry, Western Reserve University, Cleveland.

Industrial Medical Association Will Hold Program in Pittsburgh

The Industrial Medical Association of Pittsburgh will hold an all-day meeting September 28 at the Mellon Institute, Pittsburgh. Dr. Rex H. Wilson, medical director, B. F. Goodrich Company, Akron, is president of the association. Dr. Frank Gray, the president-elect, is program chairman. All interested in industrial medicine are invited to attend. Further information may be secured from Dr. Merle Bundy, secretary of the association, at the Jones & Laughlin Steel Corporation, 2709 East Carson Street, Pittsburgh. Other Ohio physicians taking an active part in the organization are Dr. Donald Kelly, Cleveland, who is vice-president, and Dr. Daniel Dougherty, medical director of the Ford plant, Cleveland, who is on the board of directors.

Among subjects on the program are: "Arthritis in Industry"; "Opportunities for Education for the Industrial Physician"; "The Scope and Responsibilities of the Part-Time Industrial Physician," and other timely topics.

American Fracture Association

The American Fracture Association has scheduled its annual meeting in the Drake Hotel, Chicago, November 20 - December 1. The organization also has scheduled an instructional course in fractures in conjunction with the Cook County Graduate School of Medicine to be held on November 28, the day preceding the annual meeting. Details may be obtained from Dr. H. W. Wellmerling, 610 Griesheim Bldg., Bloomington, Ill.

Do You Know? . . .

New Surgeon General of the U. S. Public Health Service is Dr. LeRoy E. Burney, former health director of Indiana, who has been assistant surgeon general. He succeeds Dr. Leonard Scheele, who resigned to become president of Warner-Lambert Pharmaceutical Company.

* * *

Dr. Ralph W. Eddy, Cincinnati, has been named an alumni trustee of Marietta College. He was awarded an honorary degree of Doctor of Science by the college in 1952.

* * *

Dr. Frank H. Mayfield, Cincinnati, recently named First District Councilor of the Ohio State Medical Association, left in August for tour of U. S. Army hospitals in France and Germany as consultant in neurosurgery for the Army Surgeon-General.

* * *

Three Ohio physicians—Drs. Rivington Fisher, William Ashe and James Paul Hughes, all of Columbus—were named Fellows of the Industrial Medical Association at the recent Industrial Health Conference in Convention Hall, Philadelphia.

* * *

Dr. Robert M. Zollinger, head of surgery, Ohio State University, is new chairman of Veterans Administration's Special Medical Advisory Group, succeeding Dr. W. G. Scott.

* * *

Dr. M. A. Blankenhorn, Cincinnati, is heading up a study by the American College of Physicians, financed by U. S. funds, to evaluate the practice of internal medicine in hospitals and to establish minimum standards of quality. The study will not cover standards of efficiency as stated in the Aug. 15 issue of OSMAGram.

* * *

Ermal E. O'Brien, D. D. S., former dental consultant with the Illinois Department of Health, has been named the new chief of the Ohio Department of Health's Division of Dental Hygiene. He succeeds Harry M. Millhoff, D. D. S., who retired after 16 years of service.

* * *

New officers of the Northern Ohio Pediatric Society are Dr. Chauncey W. Wychoff, president; Dr. William M. Champion, president-elect; and Dr. James B. Stewart, secretary-treasurer, all of Cleveland.

* * *

Formation of the Health Insurance Institute, to speak for the companies in the health insurance business, has been announced at its offices, 488 Madison Avenue, New York. It will be the public relations arm of the Health Insurance Association of America, which was established last April by 243 life and casualty insurance companies writing health insurance policies.

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New Social Security Amendments . . .

New Disability Benefits Outlined with Other Sweeping Changes in Law; Report on Other Medical-Health Bills Passed by the Congress

THE Social Security Bill, H. R. 7225, is now the law of the land as Public Law 880. Known in official circles as the Social Security Amendments of 1956, the bill was signed by the President after quite a scrap in the Congress.

The new law embraces a wide range of changes in the Old Age and Survivors Insurance, providing compensation for disabled workers after age 50, full benefits for widows at age 62, and revisions in the public assistance programs.

BRICKER OPPOSES AMENDMENT

The measure as passed by the House a year ago contained a disability provision. This was deleted by the Senate committee which heard the bill. When the measure came before the Senate for a vote in the closing days of the session, an amendment to restore the disability provision, known as the George Amendment, was introduced. This was adopted despite active opposition on the part of the medical profession, industry and the Eisenhower administration. The vote was 47 for the amendment and 45 against. Senator Bricker, senior senator from Ohio, voted against the disability amendment. Senator Bender did not vote. The bill with the disability provision then was approved by the Senate.

HOW IT WILL WORK

Physicians will be called upon to certify disability in a worker much the same as they do now under the "disability freeze" provisions of the Social Security program, unless and until new regulations are issued. Under the disability freeze program, the physician makes his medical findings and turns in his report to the state agency in charge, in Ohio the Bureau of Vocational Rehabilitation. The decision then is made by the agency, based on vocational as well as medical findings, as to the applicant's disability.

HIGHER TAXES

Increased Social Security taxes to finance the program go into effect on January 1, 1957. The present 2 per cent for employer and employee on the first \$4,200 of wages will be increased to 2½ per cent for each. Self-employed now paying 3 per cent will pay 3-3/8. Self-employed physicians are still exempt from the taxes but are required to pay on salaries of their employees. Payments of benefits under the disability program become effective July 1, 1957.

Full benefits are payable to widows at age 62 under the new law. Employed women and wives may elect to receive reduced benefits after age 62.

Various estimates have been made as to the number of workers who will be eligible for the

new disability benefits. One estimate puts the figure at 340,000 the first year.

HOW TO QUALIFY

To qualify for the new disability benefits, a worker must conform to the following requirements among others:

Be 50 years old or older.

Prove he is unable to engage in any substantial gainful activity. "Substantial" is not defined but may be qualified later by agency regulations.

Have a "medically determinable physical or mental impairment which can be expected to result in death or be of long continued and indefinite duration."

Submit physician reports detailing diagnosis, etc.

Accept any available state vocational rehabilitation services unless there is good cause for refusal.

Have a permanent disability at least six months before collecting payments.

Another provision of the new law increases federal grants to states by \$146 million a year to raise the federal-state payments to needy persons under the four public assistance programs—needy aged, blind, disabled and dependent children.

The new law extends Social Security coverage to about 225,000 persons not previously included, among them several professional groups. Doctors of Medicine constitute the only sizeable group in the nation not covered, aside from government workers.

OTHER LEGISLATION IN 1956

Although H. R. 7225 got most of the spotlight during the 1956 session of Congress, other medical-health legislation of importance was enacted. Following are some of the measures which have become law, the explanations being taken from Gerald Gross's *Washington Report on the Medical Sciences*:

MEDICAL RESEARCH FACILITIES

Public Law 835 authorizes a 3-year program of Federal matching grants to public and nonprofit institutions to assist in construction, expansion, improvement or equipping of facilities for research in the medical and allied sciences. Maximum of \$30 million appropriated for 1956-57.

MEDICAL CARE FOR SERVICEMEN'S DEPENDENTS

Public Law 569 gives Secretary of Defense wide latitude in fixing terms for medical care and hospitalization of military dependents by civilian resources, at government expense. Civilian care

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Phone: 829 R

BELLE QUICK
5780 Greenlawn Rd.
Hamilton, Ohio
Phone: 23876

MARGARET MONDHANK
546 Hadley Ave.
Dayton 9, Ohio
Phone: OXmoor 6220

DOROTHY MILLS
1024 Kunz Ave.
Middletown, Ohio
Phone: 23829

RUTH POWERS
R. R. 1 - Box 491
Independence, Ky.
Phone: FLettwood 7733

program now being planned by Defense Dept., in cooperation with organized medicine. Scheduled inauguration date is December 8, 1956.

COMMISSIONING OF OSTEOPATHS

Public Law 768 gives statutory sanction for commissioning doctors of osteopathy in Medical Corps of Army, Navy and Air Force. This act is permissive. Armed forces are under no compulsion to commission doctors of osteopathy.

CAREER INCENTIVES IN ARMED SERVICES

Public Law 497 was enacted at urgent request of the Administration to help stem resignations from Medical and Dental Corps, strengthen procurement of doctors for career duty and induce more 2-year Reservists to volunteer for extended service or apply for transfer to the Regulars. Act increases constructive service credit so as to hasten promotion and, of more immediate interest, raises the special pay of medical and dental officers by \$50 to \$150 monthly, depending on the length of active duty.

TRAINEESHIPS AND HILL-BURTON EXTENSION

Public Law 911 inaugurates Federal traineeships in public health, graduate nursing and practical nursing; gives Hill-Burton hospital construction law two more years of life, until July 1959, and broadens Public Health Service authority to support mental health projects, demonstrations and experiments.

SURVEYS OF ILLNESS

Public Law 652 directs Public Health Service to conduct continuing surveys of disease and injury incidence, also special studies. Projects will be undertaken with close cooperation and participation of Census Bureau. Findings can influence size and direction of governmental and private support of research; medical education; public health administration, and Capital's future role in medico-economic affairs.

NARCOTIC CONTROL ACT

Public Law 728 amends Internal Revenue Code, Narcotic Drugs Import and Export Act and other U. S. laws to increase penalties for illegal possession, transportation and sale of narcotics and marihuana.

MEDICAL BENEFITS IN U. S. FOREIGN SERVICE

Public Law 828 grants additional medical expense protection to U. S. Foreign Service employees and their dependents stationed abroad. Main changes affect dependents, giving them full medical and hospital expense coverage up to 125 days treatment (with a \$35 deductible) and authorizing Federal payment for costs of necessary medical travel by dependents as well as employees.

ALASKAN MENTAL HEALTH

Public Law 830 is for the purpose of "vesting in the Territory of Alaska authority comparable

in scope to that of the States and other Territories of the United States in the field of mental health." It provides funds to help Alaska plan for hospitalization of its own mentally ill (instead of sending patients to the mainland) and for hospital construction, with a million-acre land grant included.

DONABLE PROPERTY FOR CIVIL DEFENSE

Public Law 655 makes public and nonprofit, tax-exempt institutions and agencies engaged in civil defense activities eligible for receipt of Federal surplus property on essentially the same basis as public health, hospital and educational institutions.

MISCELLANEOUS

Public Law 492 gives commissioned personnel of U. S. Public Health Service status comparable with that of members of Army, Navy and Air Force medical departments.

Public Law 854 provides for salary increases to Surgeon General and next four ranking officers of USPHS; Special Assistant (Health & Medical) to Secretary of HEW; Assistant Secretary of Defense (Health & Medical); Chief Medical Director of Veterans Administration, his deputy and assistant chiefs, and the so-called "super grade" medical and biological scientists in USPHS and other Federal agencies.

Public Law 1022 adds qualified medical research organizations to list of institutions for gifts to which individuals may take deductions up to 30 per cent of adjusted gross income.

Public Law 411 extends duration of financial assistance to the states for procurement of poliomyelitis vaccine.

Ohioan Is in Key Post for National Crippled Children Program

Dr. James B. Johnson of Newark, Ohio, is serving as convention chairman for the first annual meeting of the National Society for Crippled Children and Adults, which will be held for four days beginning October 28, in Washington, D. C. Speeches and papers will be confined to the morning sessions, and afternoons will be devoted to seminars and institutes covering various phases of rehabilitation.

Attention: Toledo Area Doctors!

Federal narcotics officials have requested *The Journal* to advise readers in the Toledo District that, inasmuch as there is no narcotics agent in that district at present, persons desiring information, advice or services from a narcotics agent should communicate with the Federal Narcotics Bureau in either Columbus or Detroit. The Columbus Office is located in the Federal Building and the phone number is Capital 1-6411. The Detroit Office is in the Federal Building and the phone number is Woodward 3-9330.



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FOR BETTER
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*"Because of the better and more consistent absorption of penicillin V from the intestinal tract, it would appear that this type of penicillin is preferable to penicillin G when oral administration is to be used."*¹

1. Martin, W. J., et al.: J.A.M.A. 160:928 (March 17) 1956.

PEN•VEE•Oral and PEN•VEE Suspension permit new dependability in oral-penicillin therapy—dependable stability in gastric acid, dependable and optimal absorption in the duodenum. "Not being destroyed by acid in the stomach, as is penicillin G, penicillin V remains available in larger amounts for absorption."¹

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Oral
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Suspension

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New Administrative Assistant Joins OSMA Headquarters Staff

A new member has been added to the Headquarters Office staff of the Ohio State Medical Association by authority of The Council. He is Charles W. Edgar, Jr., who comes to the new post as administrative assistant from the editorial staff of the *Springfield Daily News*, a position he has held for the past six years.

A background in medical organization work also stems from Edgar's association with the Clark County Medical Society. His interest in this field dates from 1950 when he prepared and

edited a special Sunday section of the local newspaper devoted to the 100th anniversary of the founding of the Clark County Medical Society. Since then he has worked in an unofficial capacity as public relations consultant for the Society, editing pamphlet-type material and other publication matter on medical topics. He helped with *The Clark County Medical Society*



C. W. EDGAR

—1815 to 1955, a history of the Society compiled by Dr. D. J. Parsons and published by the Society. Last year his association with medical organization became even closer when he was named administrative secretary of the Clark County Medical Society on a part-time basis.

A native West Virginian, Edgar entered West Virginia University in 1939, and, after three years of intervening service with the Army, received the degree of B. S. in Journalism, Class of '46. In College he was president of Journaliers, men's professional journalism honorary fraternity. He also was active in the college press club, Phi Sigma Kappa, intramural sports, the men's glee club, and other extracurricular functions.

His first full-time position in newspaper work was that of city editor of the *Canton (Ill.) Daily Ledger*. From there he went to the *Clinton (Iowa) Herald* and then to a post as managing editor of the *Canandaigua (New York) Daily Messenger*.

Edgar has a good background in organization work and a bent in that direction. He comes to the Columbus office well recommended by those with whom he has been associated in Springfield.

In Canton, Iowa, he helped organize the Junior Chamber of Commerce and was voted "Mr. Jaycee" by that organization in 1947. In each of his two years with the *Canandaigua Messenger* he was accorded the New York State Citizens' Public Expenditures Survey's annual award for "editorial excellence and news coverage in the field of local government." During his stay there

also he was active in the local Chamber of Commerce, serving on its public relations and ethical practices committees.

His liking for the newspaper-promotion type of article has directed his efforts behind such movements as hospital expansion programs, emergency medical service, blood banks, disaster relief, tuberculosis campaigns, diabetic drives, as well as many projects of the medical profession itself.

Edgar is married and the father of two children.

As a member of the OSMA staff, Edgar will work with several of the association's committees; do general assignment work; assist in preparing news articles for *The Journal*; and eventually engage in field work with county medical societies.

American Medical Writers' Association To Meet in Chicago, Sept. 28-29

Physicians interested in writing for medical publication, or those who wish to improve their writing, will wish to attend the 13th Annual Meeting of the American Medical Writers' Association, Friday and Saturday, September 28 and 29. Sessions will be in the Hotel Morrison in Chicago.

Among speakers on the program will be Dr. Jonathan Forman, Columbus, Editor of *The Journal*, who will speak on the subject, "Workshops in Medical Writing for Medical Societies." Dr. Forman is chairman of the advisory committee for the Medical Writers' Association.

Physicians interested in becoming associated with the organization or obtaining additional information may write to Dr. Forman in care of *The Journal* or to Dr. Harold Swanberg, Secretary, 209-224 W. C. U. Bldg., Quincy, Ill.

The meeting is coordinated with the annual meeting of the Mississippi Valley Medical Society which meets at the same place September 26-28.

Big Sale of AMA Pamphlets

More than 396,000 health education pamphlets were sold by the AMA's Bureau of Health Education during the 12 months ending June 30, 1956. An analysis shows that the largest single group of pamphlets sold is 69,000 on the health of the school age child. Mental health pamphlets were second with 35,574; accidents and first aid 25,575; teeth 18,674; nutrition and diet 18,000; maternal health 17,296; physical fitness 15,319, and heart and circulation 12,400.

The Ohio State University Development Fund has announced receipt of a \$16,560 grant from the Sister Elizabeth Kenny Foundation, the second of such to aid research in physical therapy at the university. Research will be directed by Dr. Ralph E. Worden, director of the OSU Department of Physical Medicine and Rehabilitation.

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*Schwartz, E.: New York J. Med. 56:570, 1956.

provides restoration of breathing capacity — Relief of symptoms [bronchospasm, cough, wheezing, dyspnea] is maintained for long periods with relatively small doses.*

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Physicians on Hospital Boards . . .

This Arrangement Would Be Valuable and Appropriate, Assistant Director of American College of Surgeons Points Out in Address

AT its 1956 Annual Meeting in Cleveland, the House of Delegates of the Ohio State Medical Association adopted a resolution recommending election of representatives of the medical staff of a hospital to the governing board of the hospital. This information has been transmitted to each County Medical Society, with a suggestion that it urge hospitals in its area to take such action.

In view of this action by the House of Delegates of the Association, a discussion of the subject, "Physician Membership on Hospital Governing Boards," by Robert S. Myers, M. D., assistant director, American College of Surgeons, is quite pertinent and informative. Dr. Myers' talk was made before the 1955 convention of the Michigan Hospital Association. It was published in the January-February issue of the American College of Surgeons Bulletin. It is reproduced here for the information of members of the Ohio State Medical Association:

* * *

TEXT OF ADDRESS

There is increasing concern in the American medical profession that the control of medical practice is being concentrated in the hands of lay people who constitute hospital governing boards. This concern has led to a swelling demand from the medical profession that physicians be privileged to serve on hospital governing boards, and there is abundant and well-publicized evidence during the past four years from such widely separated places as California, Connecticut, Florida, Indiana, Iowa and Washington that the profession intends to press its claims. There is also evidence that hospitals will resist these claims. Since a showdown between physicians and hospitals might affect adversely the care of patients, whose welfare is the only reason for the existence of hospitals, it is essential that the conflict be resolved with justice and dispatch. An understanding of the background of the conflict may facilitate an early and equitable solution.

The hospital-physician conflict is the inevitable result of the illogical, jerry-built organization which characterizes most hospitals. To begin with there exists an incongruity by which the legal and moral responsibility for the welfare and safety of the patient is vested in a lay governing board which is not qualified to judge the quality of patient care given by the medical staff. Moreover, this lay governing board is placed in the untenable position of exercising the ultimate

authority over the policies and activities of a medical staff which by training and experience is expert in the sole reason for the hospital's existence—the care of the sick. Furthermore, these lay people are handicapped by the present lack of reliable and intelligible hospital statistics which could indicate the adequacy of patient care. Hospitals are indeed unique. No other organization exists in which management may be so truly frustrated and so ineffective because of its incapacity to judge the quality of its product.

SECOND IDIOSYNCRASY

The conflict is further intensified and complicated by a second idiosyncrasy of organization peculiar to hospitals. This is the emergence of an authority competitive with that of management and results from the inevitable dominance which accrues to the medical staff: Hospitals exist only for the care of the sick; this care can be given only by physicians; the patient-physician relationship is strong and abiding; the services of the physician are in constant and apparent demand; the services of the governing boards are not. Thus, there arises a level of physician power which is frequently not compatible with that of the governing board, since

This article is particularly appropriate in view of recent recommendations of the Stover Committee, adopted by the House of Delegates of the AMA in Chicago (Refer to August issue of *The Journal*, page 870). One of these recommendations was that physicians be represented on administrative bodies of hospitals.

the very tangible authority of the medical staff is subservient to the intangible authority of the governing board.

In the third place, as a result of the competitive authorities of the medical staff and governing board, frequently no direct line of authority exists by which policy adopted by the governing board can be enforced by its agent, the administrator. In such cases the authority of the administrator is either ignored or is not respected by either the governing board or the medical staff, and the required point of single contact between the governing board and the medical staff, so essential for adequate administration, is

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absent. It is little wonder that such an administrator is frustrated and that the hospital acquires a split body and a split personality.

ESTABLISH CHAIN OF AUTHORITY

What then should be done to resolve the hospital-physician conflict? The answer seems apparent: Create an effective and logical hospital organization in which authority proceeds from a competent governing board directly to the administrator and through him to the heads of the various departments of the hospital—medical staff, paramedical personnel, business office, et cetera. This authority must be definite, direct and respected by all parties. Of prime importance is the establishment of a governing board which is qualified to discharge all its responsibilities, the most important of which is the maintenance of adequate patient care. Since this requires the governing board to understand the effectiveness of the professional work of the medical staff, it is logical and reasonable to place physicians from the active staff on the governing board. This suggestion is contrary to usual hospital policy, and it is thus necessary to evaluate the stated objections to such physician participation. Over the years the following reasons (in italics) have been offered, and are still used, to exclude physicians from hospital governing boards.

EXCUSES FOR EXCLUDING PHYSICIANS

1. *Membership on the governing board gives individual physicians undue publicity and possible professional and financial advantage over their colleagues.*

This statement attaches unwarranted prestige to board membership which is usually a labor of love and does not of itself increase the prestige and business of lawyers, bankers, labor leaders, housewives and other citizens who serve so ably and devotedly in this capacity. Furthermore, it reveals a naïve misunderstanding of the ethics of the medical profession in regard to personal publicity. Nothing lays a doctor open to criticism and censure by his colleagues as quickly as unwarranted publicity. It is a principle seldom violated with impunity. The statement has also been made that a physician board member might receive special consideration by the hospital admitting office in the admission of his patients to the hospital. There is no valid reason why this should be so, and this objection would be eliminated by the policy of rotation of physicians on the board.

2. *Physicians who are members of the governing board may use this position to secure unwarranted promotion on the medical staff.*

If the bylaws of the hospital specify that a physician must be a member of the active staff to be eligible for membership on the governing board, and this provision is entirely reasonable, then the only promotions possible would be to

higher rank in a service of the medical staff or to a category of unrestricted privileges in a particular specialty. Both of these promotions are determined by various responsible committees of the medical staff on the basis of professional competence and not because of pressure tactics.

3. *Physicians appointed to the governing board are not regarded as representatives of the medical staff.*

4. *Physician representation on the governing board creates jealousy and frustration among other physicians who have no such connection.*

5. *The physician member of the governing board may be regarded as a "stool pigeon" who informs on the medical staff.*

6. *The specialty or particular field of interest of the physician board member might influence his recommendations of equipment and personnel to the disadvantage of other services of the medical staff.*

Each of these objections may be disposed of by a requirement in the hospital bylaws specifying that the term of an individual physician on the governing board is limited to no more than two consecutive years at one time and that physician board members are to be elected by the members of the active medical staff. Rotation of the privilege of serving on the governing board would thus be assured, and any member of the active medical staff would be eligible for the position.

7. *The physician on the governing board may be exposed to double jeopardy in certain legal actions.*

It is not known how infrequently such an eventuality might occur, but it would seem that the physician board member is relatively secure from this hazard. However, this is an objection which should properly be considered by the physician, since he provides for his own personal professional liability insurance.

8. *The physician on the governing board might express his own opinion and not that of the medical staff.*

The physicians, like any other member, are on the board in the interest of the patient and not to represent any special group.

9. *The physician on the governing board may use his influence in the employment of hospital personnel.*

This assumes wrongly that physicians are less honorable than other members of the board. It also fails to recognize that the now existing dual authority in hospitals permits physicians to bypass the administrator and to exert considerable influence on the employment of hospital personnel.

10. *Leading authorities in the hospital and medical fields advise against physicians being on governing boards.*

It is true that the American College of Sur-

For Control of Acute Agitation



- In the acute alcoholic
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- In the drug addict

A potent new agent in chemopsychotherapeutics, SPARINE has demonstrated a marked ability to calm and relax acutely agitated patients.^{1,2} Without inducing disabling lethargy or dulling perception, SPARINE "... is effective in ... maintaining these subjects in a quiescent detached state. ..."¹

Given intravenously, SPARINE rapidly brings patients under control. Given orally or intramuscularly, it promotes patient accessibility, fosters psychotherapeutic contact, and facilitates over-all management. Parenteral administration of SPARINE is not painful and does not cause tissue necrosis at the site of injection.

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1. Fazekas, J.F., et al.: J.A.M.A. **161**:46 (May 5) 1956. 2. Mitchell, E.H.: J.A.M.A. **161**:44 (May 5) 1956.

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geons, during the time it conducted the program of hospital standardization, discouraged physician representation on governing boards and deducted a few points from the rating of any hospital which had physicians on the board. However, the Joint Commission on Accreditation of Hospitals, which succeeded the College in this program, does not share this view and does not penalize hospitals having physicians on the board. Moreover, the 1953 report of the Joint Committee on Hospital-Physician Relationships of the Boards of Trustees of the A. M. A. and the A. H. A. recommends that "members of the medical staff can be members of the hospital governing board" as one method by which the medical staff may have access to the board.

CONCERNING PROFIT

11. *Since it is unethical for lay members of a governing board to profit from business transactions with the hospital, it is equally unethical for a physician to serve on the board of a hospital to which he admits patients.*

This objection fails to recognize that profit for a lay member of the board would be the direct result of a decision by a board on which he sits, whereas profit for a physician must come from professional practice, the increase of which is not influenced by a decision of this board.

12. *Admission of physicians to membership on hospital governing boards is the first step in the eventual total domination of hospitals by the medical profession.*

The value of community participation in the management of the hospital is well established and is well recognized by the medical profession. The profession has no desire to assume the total responsibility for management of the hospital.

THE ADVANTAGES

Having thus revealed each of these objections to be invalid, it is timely to indicate the distinct advantages of having physicians on governing boards of hospitals.

1. Physicians can contribute much to the effectiveness of any policy-making body, for they are trained in deductive reasoning and are accustomed to making important decisions. They take their responsibilities seriously and discharge them with distinction. Moreover, physicians have first-hand knowledge of the deficiencies and needs of hospitals, both from their own observations and from their patients' comments.

2. Physicians alone can explain medical matters to lay members of the governing board, and they can do this best when they participate as responsible members of the governing board. Joint conference committees, composed of representatives of the governing board and the medical staff, afford only limited communication between the board and the staff and rarely acquaint the entire board with an adequate

understanding of factors affecting patient care. It is logical that a physician should participate as a member of the board when decisions on medical matters are made by the board.

NATURAL TALENTS AND SPECIAL KNOWLEDGE

3. Physicians are an integral part of the hospital team and of the community. It is reasonable and democratic that they be given representation on the board. Moreover, since it is recognized that representatives from all other elements of the community—business, law, clergy, labor, housewives—bring to the governing board the benefits of their natural talents, special training and experience, it is entirely logical that the physician's special knowledge of medicine would be of value to the board.

4. Physicians, as part of the hospital team, should take their share of responsibility for the nonmedical problems which face administration of hospitals. The reasonable reduction of expenditures and the raising of money should be the concern of the medical staff and will be, if physicians are integrated properly into the policy-making body of the hospital.

AN ULTIMATE AUTHORITY

5. Physician membership on the governing board will insure the ultimate authority of the governing board and will abrogate the competing authority otherwise assumed by the medical staff. Once the governing board is reconstituted to include physician members, it is necessary that a distinct line of authority be laid down from the board to the administrator and through him alone to the head of each department of the hospital. Any attempt to bypass the administrator from above or from below violates a cardinal principle of effective organization and must not be tolerated. Policy established by a governing board which includes physicians is binding on all components of the hospital, including the medical staff. There is no reason to anticipate failure of the medical profession to co-operate. In fact, it is the experience of hospitals which have welcomed physicians to membership on their governing boards, that physician-participation has created an effective and harmonious hospital organization not previously present.

Of necessity, hospitals and the medical profession are joined in permanent wedlock, for one cannot now exist without the other. This marriage must succeed, not only to protect the patient but also to perpetuate the American ideal of free enterprise for hospitals and the medical profession. But if this union is to prosper, there must be a true partnership between hospitals and physicians. This will not be realized until physicians participate in the management of hospitals and share in the responsibilities attending this privilege.

Data on Absenteeism Studied To Find "Cure" For Excessive Amount

An industrial medical director has suggested, after a study of 28,000 workers, that the number of absences because of illness can be reduced by a "grass roots" approach to the problem.

Dr. Leo Wade, of the Esso Standard Oil Company, New York, proposed a "human relations" program in industries "to make sure that each worker is properly assigned so that he can do a 100 per cent job without harm to himself or his associates." The program would be run by the medical director, personnel officer, and department supervisors.

A certain amount of sickness absenteeism is inevitable, but excessive absenteeism may be a sign that a worker is not properly assigned or is incapable of adjustment in industry, he said.

Dr. Wade found in his study, reported in the *Archives of Industrial Health*, published by the American Medical Association, the following:

Women employees were absent more than twice as often as men—2,772.3 absences per 1,000 women per year compared with 1,054.8 absences per 1,000 men per year.

The average number of days lost per absence among women was less than half that for men—3.6 and 8.8 days.

The average number of absences per year tended to decrease slightly as employees grew older; however, the average duration of absences increased "strikingly" for men.

One day absences made up a smaller portion of the total absences with each successive decade, while long term absences increased. This may result in part from a change in the disease pattern with increasing age.

Respiratory disease accounted for almost half of the total absences, while gastrointestinal disease was responsible for slightly more than one-fourth. Cardiovascular disease was responsible for less than 2 per cent of the total.

With advancing age, the frequent mild upper respiratory or gastrointestinal upsets were replaced by infrequent serious life-threatening diseases.

The major part of the total number of absences was due to a relatively small number of employees—often the same employees year after year.

The weather, often blamed for increased absenteeism, apparently played no part in it. The only correlation found was that there were fewer absences on higher temperature days.

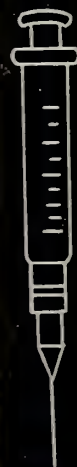
Shift work did not increase absenteeism.

Morale factors, such as a supervisor's personality, type of work, and home situation, were of "extreme importance" in influencing the rate of absences.

One and two-day absences frequently were related to weekends or holidays. A study of one refinery in 1948 showed that 54.8 per cent of such absences immediately preceded or followed otherwise legitimate time off.

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Dr. Wade



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HORMOGEN R-A: Aqueous suspension in 10 cc. multiple dose vial: each cc. represents Estrone U.S.P. 2 mgs., Potassium Estrone Sulfate 1 mg.

INDICATIONS: Menopause syndrome, for control of uterine bleeding of endocrine origin, senile vaginitis, kraurosis vulvae and puritis vulvae.

DOSAGE: ½ cc. to 1 cc. once or twice a week.

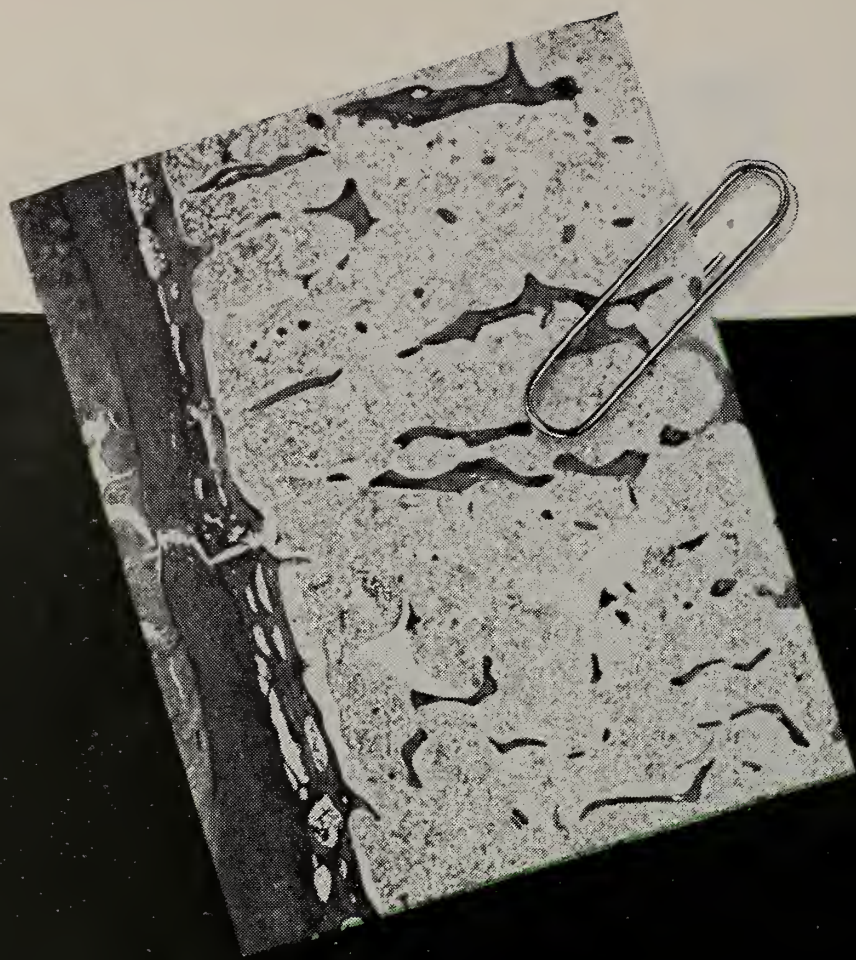
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*Reifenstein, E. C., Jr., and Albright, F.: J. Clin. Investigation 26:24, 1947.

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Ohio Services for Crippled Children . . .

Medical Advisory Board to State Agency Makes Several Modifications And Additions to Medical Policy in Regard to Treatment of Patients

MODIFICATIONS and additions to the medical policies of Ohio's Crippled Children's Services were adopted at a recent meeting of the Medical Advisory Board. These services are a function of the Ohio Department of Public Welfare and are financed by State and Federal funds. For a detailed description of the services, refer to page 605, June issue of *The Journal*.

Following is a report of some of the policies adopted and actions taken by the Medical Advisory Board:

1. Fee Schedule of Physicians and Dentists—

(a) A Committee was appointed to study and recommend the revisions of present fees for surgical and other procedures (medical and dental).

2. **Cardiac Centers in Hospitals re Catheterizations and Surgery**—A committee was appointed to personally visit the other cardiac centers in the state, and not now recognized by the state CCS, to report to the Medical Advisory Board if any others will be so recognized for cardiac procedures on state cases. At present patients under the program are cared for in the following Cardiac Centers:

- (a) Children's Hospital—Columbus
- (b) Children's Hospital—Cincinnati
- (c) Cleveland Clinic—Cleveland
- (d) University Hospital—Cleveland

3. Where a fee paid to a surgeon by an Insurance Company is greater than the fee allowed by our schedule, the surgeon has the choice of accepting the higher fee.

4. **Burn Cases** shall not be accepted under state care from the day of the accident. They must be under hospital care for at least one month before being eligible for acceptance by the CCS.

5. No case will be accepted for care by the CCS that will require a lengthy period of only medical treatment prior to being ready for surgery. Ex: "Adreno-genital Syndrome" requiring cortisone for 4-5 years prior to plastic surgery.

6. **Annual CC-5 Re-evaluation**—It has been recommended that all physicians supervising state cases be required to submit an annual re-evaluation of the case on a new CC-5. It will be the one responsibility of the department to give the physician prior notice when such a re-evaluation is due.

7. **Physician to Physician Relationship**—It was the unanimous opinion of the Board that the

referring physician (usually the family physician) be at all times completely informed by the surgeon or supervising physician of the case as to the progress of the case. The ethics of the physician to physician relationship is self-evident. The family physician has too often felt ignored and forgotten after referring a case to a specialist. It must always be kept in mind that the family physician will have a continued interest in the patient's overall medical needs in addition to the condition for which the state accepts responsibility. Form CC-5 will be revised to include name of family physician so that he may receive copies of progress reports.

8. **Hospital Authorizations**—It is now the accepted policy for the department to authorize only: (a) 30 days hospital in acute cases; (b) 90 days in Convalescent cases.

At the end of each period, the hospital must request in writing for future authorization and submit progress reports to justify the request. It is the responsibility of the hospital administrator to remind the supervising physician that such authorization is needed and that he must approve it.

Failure in the future to comply with this ruling will justify the Business Office in denying payment for unauthorized hospitalization.

9. **Prior Requests**—Physicians supervising state cases must make prior request and receive authorization from the CC Service for (a) Surgical procedures; (b) Calling in consultants; (c) Hospitalizing the case.

Failure on the part of the physician to follow this procedure will result in non-payment, since the department's policy is to make payment only on authorized services. The department must have prior knowledge of all contemplated procedures in order to have the opportunity to accept or reject.

10. **Out-of-State Referrals**—It was the unanimous opinion of the Board that there is no need for any case to be sent to another state for treatment. In the rare instance where a procedure or facility is available only in another state may the patient be sent there for the needed treatment. Such procedure can be authorized only with consent of the Medical Director after due consultation with members of the Advisory Board.

11. **Termination of Care and Discharge from the State Program**—The Medical Director has authority, if, upon reviewing a case, he feels that it should be discharged from the state pro-

gram even if the supervising physician requests further extension.

12. **Rheumatic Fever**—The Department has had no rheumatic fever program as such nor contemplates one in the future. However, the Board agreed to the following:

(a) Patients who can be helped by surgery shall be accepted.

(b) For a one year trial period, the Board decided that the CC Services may accept rheumatic fever patients needing three to six months convalescent care in a convalescent hospital or a foster home for purposes of rehabilitation providing there are no other facilities available.

13. **Cerebral Palsy**—The department will, in the future, be far more discriminatory in accepting such cases than in the past. When indicated, it will reserve the right to ask that such a child be evaluated at a Cerebral Palsy Center in regard to trainability, prognosis and mentality. On basis of such a team concept evaluation the Department will determine if:

(a) Child is acceptable for the program; (b) Is to be accepted for a limited trial period; (c) Is to be rejected.

12 Ohioans Voted into American College of Physicians

When the American College of Physicians held its 37th annual session in Los Angeles, it elected 12 Ohio physicians to Fellowships of Associate memberships in the organization.

The following Ohioans were elected as Fellows: Drs. John Dodd Cameron, Defiance; John Weaver King, Cleveland; and David Karl Scheer, Toledo.

The following were elected as Associates, or Junior Members: Drs. Anthony Thomas Anton, Springfield; Paul Emery Foldes, Cincinnati; Paul Milton Kohn, Cleveland Heights; Mark F. Moots, Canton; Robert Alvin Keller, Erwin Levin, Paul Andrew Nelson, Frederick Alan Oldenburg and Louis Rakita, all of Cleveland.

Compulsory Hospitalization of TB Patients Rests with Board

The syllabus of an opinion recently given by Attorney General C. William O'Neill reads as follows:

"(1) The duty as prescribed by Sec. 339.40, Revised Code, of removing to a tuberculosis hospital a person found suffering from pulmonary tuberculosis rests upon the board of health of the health district, in which such person is found. (2) No duty rests under the law upon the sheriff to carry out the order of a district board of health to convey to a tuberculosis hospital a person suffering from pulmonary tuberculosis who is in the opinion of the board a menace to the public health, and the board of health is without authority to impose such duty upon the sheriff."—Opinion No. 6934.

Internal Revenue Service Rejects Kintner Case as a Precedent

The Internal Revenue Service has ruled that a group of doctors who adopt the form of an "association" in order to obtain the benefits of corporate status for the purposes of section 401 (a) of the Internal Revenue Code of 1954 (which permits the establishment of tax-deferred pension plans for employees) is in substance a partnership, and the doctor-members are employers and therefore not employees.

The ruling, reading in part as follows, opposes the position taken by the Federal Circuit Court of Appeals in the Ninth District in the Kintner Case:

"It is held that a group of doctors who adopt the form of an association in order to obtain the benefits of corporate status for purposes of section 401 (a) of the Internal Revenue Code of 1954 is in substance a partnership for all purposes of the Internal Revenue Code. It follows that the doctor-members are employers and therefore not employees. . . . Furthermore, any period of service as members of a prior partnership will not be credited as a period of employment for purposes of the above section. The contrary position expressed in the case of *United States v. Arthur R. Kintner* . . . will not be accepted by the Internal Revenue Service as a precedent in the disposition of other cases involving similar fact situations."

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many patients would lose
their appetites, a conse-
quence of the salt-free diet
which has occasionally been
known to cause serious
malnutrition."*

*Modell, W.: *The Relief of Symptoms*, Philadelphia, W. B. Saunders Company, 1955, pp. 265-266.

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In Our Opinion:

Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

NO ALTERNATIVE BUT TO MEET THE STANDARDS

A news article regarding the proposed revisions in the Principles of Medical Ethics, to be voted on by the AMA House of Delegates this Fall, got a big play in the Ohio press.

One newspaper, commenting on the subject editorially, said: "Doctors—with very few exceptions—have always held to the highest standards of ethics. One responsibility is paramount to all others—to do all for the patient that skill and knowledge will permit. There is no room in medicine for those who will not or cannot uphold such standards."

In our opinion no physician dare do less than live up to the confidence expressed in the final sentence of the above quotation.

BAIER AT IT AGAIN; OUR ADVICE THE SAME

N. H. Baier, of Chicago, is at it again. Ohio physicians have been receiving yellow cards from him, asking to buy their "surplus drugs and samples." He's not a physician. Some time ago, we commented on Baier and his activities under the heading, "Beware of Baier, Is Our Suggestion." Here's what we said:

"Investigation shows that Baier is just an individual who apparently is looking for an easy buck. The Food and Drug Administration in its investigation of him found that it hasn't found anything yet which would warrant prosecution but it did offer the comment that 'such a business is definitely full of hazards to the public and should be discouraged.' No one seems to know how Baier disposes of the drugs and samples which he undoubtedly gets from some physicians.

"In our opinion physicians should have no dealings with Baier or anyone else engaged in an enterprise of this kind."

WATCH YOUR STEP ON LISTING IN DIRECTORIES

Here's a question which comes up from time to time: "Is the listing of one's name in a commercially sponsored advertising directory in keeping with the Principles of Medical Ethics?"

The Judicial Council of the AMA has answered that one. Following is the gist of the Council's opinion.

The Principles proscribed the solicitation of patients directly or indirectly. The House of Delegates of the Association has expressed disfavor with the practice of permitting one's name to be

listed in a commercial advertising directory because it is or may be interpreted to be the indirect solicitation of patients.

Most if not all, of the directories published by commercial concerns are but subtle ways of avoiding the pronouncement of the Principles of Medical Ethics concerning solicitation of patients, under a guise of buying a directory when the real intent is the purchase of the publication of the buyer's name in the directory for the purpose of obtaining patients."

A physician who uses or permits the use of his name in a commercial directory that fails to include on like terms and without discrimination the names of all licensed physicians practicing in the area served by the directory has the burden of proving that his action is in keeping with the Principles.

TWO SAFEGUARDS AGAINST MALPRACTICE

It's no news to the physician that malpractice suits are becoming an increasing hazard. What to do to combat the trend poses a tough question. Much advice has been disseminated. Among the latest is an editorial which appeared in the *American College of Surgeons Bulletin*. Reading in part as follows, it rather puts the whole problem into proper focus, in addition to offering good advice:

"Asked to sum up in a single sentence all that he has learned about the professional liability problem, a wise and experienced surgeon said not long ago: 'The doctor who is loved by his patients is never sued.'

"As practical advice today, many doctors will protest, this is poppycock. Under modern conditions of specialty practice, they ask, how can one possibly be "loved" by patients—in the way that the old-fashioned family doctor was loved?

"Possibly the goal is unattainable in actual practice, but certainly it is worth striving for—not only as a means of avoiding malpractice suits but also because the physician fulfills his role as a healer only to the extent that he enjoys the faith and affection of his patients. The time and pains taken to establish a personal, confidential relationship with the patient constitute the first line of defense against malpractice because these are among the most important ingredients of good practice.

"Next to the good will of his patients, the most important safeguard against malpractice suits is the law itself. In spite of the abuses and aberrations reported here, the law is still on the side of the competent physician. If qualified witnesses establish that the medical or surgical procedure used was in keeping with the standards of skill, care and judgment exercised by members of the profession practicing in the same or a similar locality, malpractice does not exist according to law. Of course, a jury may always



1. Moser, M.: New York State J. Med. 55:1999 (July 15) 1955. 2. Agresti, A., and Hoobler, S.W.: J.A.M.A. 157:999 (March 19) 1955. 3. Smirk, F.H.: Am. J. Med. 17:839 (Dec.) 1954. 4. Smirk, F.H., and McQueen, E.G.: J. Chron. Dis. 1:516 (May) 1955. 5. Waldman, S., and Perner, L.: Am. J. M. Sc. 231:140 (Feb.) 1956.

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arrive at a bizarre interpretation of what constitutes 'the ordinary degree of skill, care and judgment exercised by members of the profession practicing in the same locality,' but professional competence, like truth, is still the best defense."

IT TAKES MORE THAN DUES TO KEEP THE STEAM UP

It may interest members of the Ohio State Medical Association, who will pay \$25 state dues, beginning January 1, 1957, to know that the average American physician pays between \$50 and \$60 per year state society dues and that his county society dues range from \$20 to \$70 a year, depending upon whether the local society maintains an executive office.

These data were revealed in a survey among the 48 states and the District of Columbia by the Michigan State Medical Society.

Although its dues have been—and will be—modest, the Ohio State Medical Association has been able to give its members good service and able to carry on effective public relations and public education programs. The membership has never refused to go along with an increase in dues because the reasons for the increase always have been fully explained and justified. When an organization does a real job, its members will rally to its support.

True, any organization, including the OSMA, needs an adequate budget to do a real job. However, money will not buy the kind of steam and punch which it takes to carry on an effective program. These have to be supplied by energetic members. Fortunately, this Association has had such members in goodly numbers. Here's hoping this situation will last indefinitely.

"IF ONLY SOME DOCTORS COULD REALIZE THAT!"

Not long ago the magazine, *GP*, published a letter from a lay reader reciting the difficulties he had encountered in securing a physician for his son when he became acutely ill. After pointing out what he considered the splendid characteristics of the physician whom he did finally get to make the call, the boy's father wrote:

"Upon leaving, I noticed for the first time that this gentleman was driving a Cadillac, and I suddenly realized how wrong doctors and medical societies and newspaper editors and the government are on the issue of the high cost of medical care. It would not have made the slightest difference to me if this gentleman had driven up in a surplus battleship. The only thing of importance is that he came.

"The hopes and subsequent concern of men and women for their children and their loved ones is a universal emotion. It knows neither price, nor class, nor collections of material items. And it knows only gratitude for those who help in times

of crisis. This is why people sometimes associate doctors with a sacred world.

"Doctors cannot destroy this association by so-called high fees. Nor can they destroy it by accumulating more than the average citizen.

"But the association is irreparably damaged by those in their number who desert their fellow man in times of great need. If only some doctors could realize that!"

About all we can add to this is a fervent "amen" to the "amen" which *GP* put on the piece as a heading.

DOCTOR, PATIENTS AND RECORDS

Here's a question the Columbus Office has tossed into its lap from time to time by both physicians and their patients: Is the physician legally and ethically obligated to give a patient a copy of his records?

Legally, the answer is no. The records belong to the physician. They need not be revealed except on proper court order. They may be revealed to the patient or to someone else with the consent of the patient if the physician wants to do so.

Following is the opinion of the Judicial Council of the AMA on the ethical aspect of this question:

"The Judicial Council does not believe that Chapter II, Section 3 intends or requires that a physician give a copy of his records to his patient. These records are primarily the physician's own notes compiled during the course of diagnosis and treatment so that he may review and study the course of the illness and his treatment. The records are medical and technical, personal and often informal. Standing alone they are meaningless to the patient but of value to the physician and perhaps to a succeeding physician. The patient, however, or one responsible for him, is entitled to know the nature of the illness and the general course or regimen of therapy employed by his physician. The extent to which the physician must advise his patient may be limited by the nature of the illness and the character of the patient. The physician in advising his patient must always act as he would wish to be treated were he in a like situation."

Court of Appeals Upholds Conviction Of Diploma Mill Promoters

The District Court of Appeals in July upheld an earlier conviction in the Cuyahoga County Common Pleas Court of two persons charged with offering worthless medical diplomas for sale.

The two are Edward M. B. Ownen, formerly of Arcadia, Mo., and Robert J. Broadwell, of Cleveland, who were convicted by a jury and sentenced to from one to three years in the Ohio Penitentiary.

"International Voice" of Organized Medicine Offers a Challenge To American Physicians

"The international voice of organized medicine," as the World Medical Association has been called, is the only world-wide non-governmental association dedicated to free enterprise in medicine, Dr. Louis H. Bauer, secretary-treasurer of the U. S. Committee of WMA, declared.

Membership in the United States Committee of WMA will bring the individual physician the opportunity to:

Protect and promote the freedoms essential to good medical practice;

Raise the standards of medical service and health throughout the world;

Associate with physicians from all over the world in sharing professional knowledge and understanding—more than 700,000 physicians from nearly 60 countries.

Join in a world forum for solution of problems common to medicine the world over;

Read the *World Medical Journal*, the only worldwide medium for dissemination of medical information.

The World Medical Association is approved by the American Medical Association.

Membership fees are as follows: Member, \$10 per year; Patron Member, \$100 or more per year; Life Member, \$250 (no further assessments).

Check should be made payable to the U. S. Committee, World Medical Association, and mailed to Dr. Louis H. Bauer, Secretary-Treasurer, U. S. Committee, Inc., World Medical Association, 10 Columbus Circle, New York 19, N. Y.

Folder Issued About Clinic For Mentally Retarded

Available to physicians on request is a descriptive brochure of the Clinic for the Mentally Retarded, operated by the Department of Mental Hygiene and Correction under the direction of William R. Morse, M.D.

Located at 1601 West Broad Street, on the third floor of the Administration Building of the Columbus State School, the clinic specializes in the field of mental deficiency.

According to the booklet the clinic services "are available to any Ohio family desiring a voluntary study of a retarded child or adult. Requests for study may be made by parents or others responsible for the health and welfare of the retarded person; by schools, hospitals, social agencies, physicians, mental hygiene clinics, or courts. There is no charge for services."



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Rural Medical Scholarship . . .

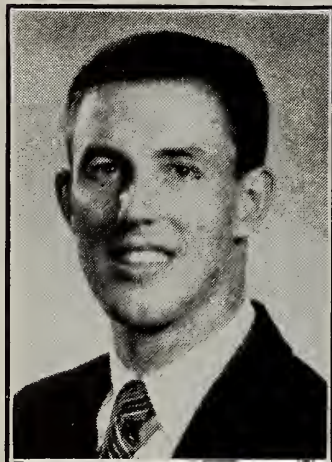
Award Goes to Canal Winchester Farm Youth Who Enters Medical School In Cincinnati; Purpose Is To Stimulate Interest In Rural Practices

CHOICE for the State Association's eighth Rural Medical Scholarship is Edwin L. Eakin, 22-year-old farm youth from Canal Winchester, who is entering the University of Cincinnati College of Medicine this fall. He will receive \$500 per year during his four years of medical school training.

The Fairfield County youth, son of Mr. and Mrs. John W. Eakin, received his premedical training at Kenyon College. He was highly recommended by members of his community and was com-

mended for his work in the Church, the Church Young Peoples' Society and other community affairs.

He earned most of his premedical college expenses by working summers on his father's farm, and during the school year as a laboratory instructor, proctor, waiter and book repairman.



EDWIN EAKIN

The Rural Medical Scholarship was instituted seven years ago by the Ohio State Medical Association to stimulate interest of rural young men and women in the study of medicine and to encourage them to become country doctors.

The Scholarship is administered by the Association's Committee on Rural Health, under the chairmanship of Dr. Edmond K. Yantes, of Wilmington, with the following other members: Drs. L. E. Anderson, Greentown; J. Martin Byers, Greenfield; E. G. Caskey, Mineral Ridge; Jonathan Forman, Worthington; V. R. Frederick, Urbana; Carl F. Goll, Steubenville; L. W. High, Millersburg; H. R. Mayberry, Bryan; Carll S. Mundy, Toledo; W. L. Murphy, Cardington; J. I. Rhiel, Port Clinton; G. N. Spears, Ironton; H. K. Van Buren, Carey; D. S. Williams, Marietta; Kenneth Taylor, Pickerington; Robert E. Reiheld, Orrville. Mr. Hart F. Page, of the OSMA staff, is secretary to the committee.

OTHER AWARD WINNERS

Previous recipients of the scholarship are: Ronald D. Moore, New Carlisle, a sophomore at Ohio State University College of Medicine; M. Robert Huston, a junior in the University of Cincinnati College of Medicine; Raymond Cole, Findlay, a senior at U. C. College of Medicine; Dr. J. Daniel Timmons, New Madison in Darke County,

an intern at the Miami Valley Hospital in Dayton; Dr. Donald Nikolaus, Johnsville in Morrow County, entering military service; Dr. Robert G. Smith, practicing medicine in Proctorville in Lawrence County; and Dr. C. Craig Wright who has completed his military service and is doing postgraduate work at OSU College of Medicine.

Another project of the State Association to stimulate interest in rural and nonmetropolitan practice is the series of lectures given annually to senior students of Ohio medical schools. During the past season the series of lectures, designed to orient students in the advantages of nonmetropolitan practices, was given at Ohio State University and at the University of Cincinnati. (Refer to June issue of *The Journal*, page 643.)

Two New Appointments to AMA Headquarters Staff

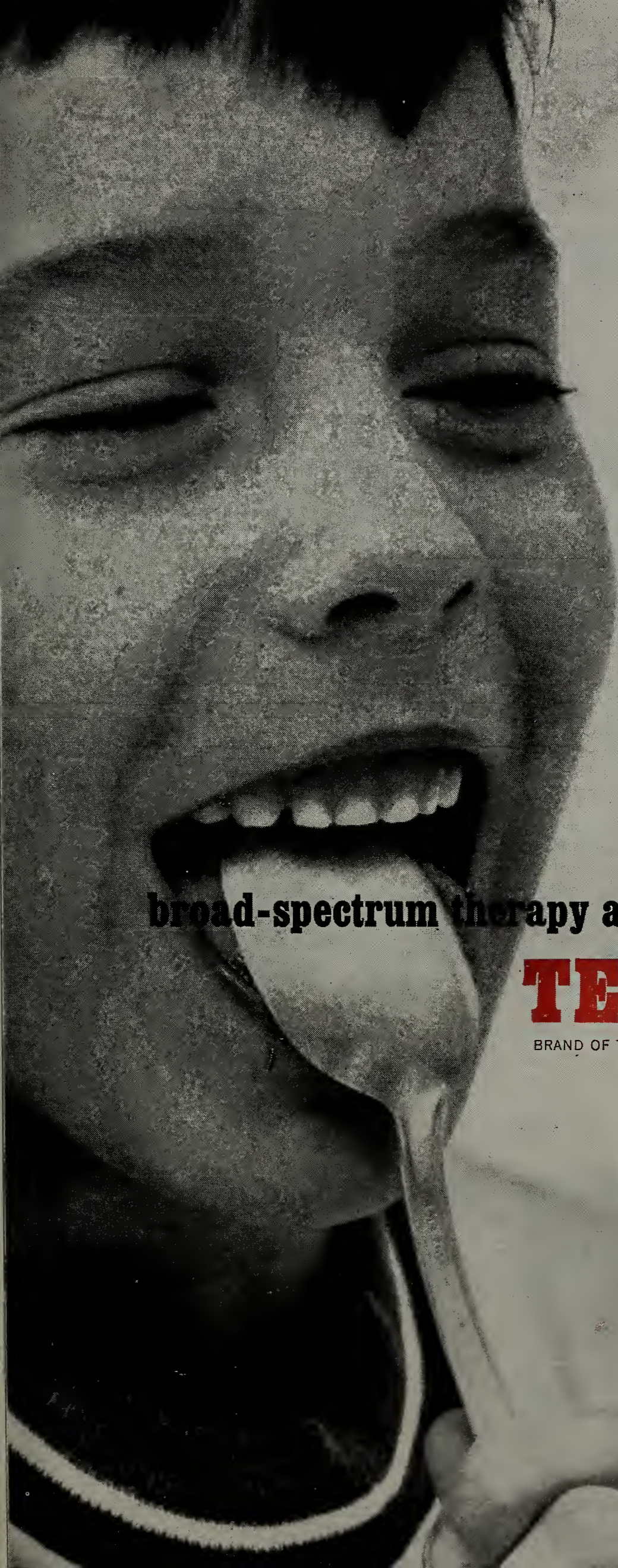
Two new people have been added to the AMA headquarters staff. Philip L. White, B. S., M. S., D. Sc., who has been with the Department of Nutrition of the Harvard School of Public Health for a number of years, is the new Secretary of the AMA Council on Foods and Nutrition, and Wallace Wesley, B. Ed., M. S., Hs. D., has been appointed consultant in health and fitness in the AMA Bureau of Health Education.

Mr. White succeeds Dr. James R. Wilson. Miss Wesley, who will work with staffers Fred V. Hein and Dr. Donald A. Dukelow in furtherance of the health of the school-aged child, has had wide experience in her field. She has taught health on the elementary, high school and college levels. In addition, she has taught general science and physical education in the public schools.

Film On Auto Crash Injuries Produced by AMA and Ford

A 15-minute motion picture on the part being played by the medical profession in the prevention of auto crash injuries has been released jointly by the American Medical Association and the Ford Motor Company.

Entitled "On Impact," the film is based on scientific information about auto injuries presented at the AMA's Annual Meeting last June. Prints are being sent to all television stations in the United States for possible use on public service time. In addition, the feature can be booked from the AMA's Film Library by county and state medical societies and their auxiliaries for showing at meetings or to the general public.



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Polio . . .

Federal Government Relaxes Its Allocation Program as Vaccine Supply Increases; Early Reports Show Marked Decrease in Incidence of Polio

TWO important developments in the supply of Salk polio vaccine have been announced: (1) The Federal government has stepped out of the allocation picture; and (2) the Ohio Department of Health has announced that the supply in the state has caught up with the demand in the previously announced priority groups.

The announcement that the U. S. Public Health Service would no longer make specific allotments of vaccine to states was made early in August. Secretary Folsom made the announcement on advice of the retiring Surgeon General Scheele and the National Advisory Committee on Poliomyelitis Vaccine. This action followed announcements that in July as many as 18 states turned back vaccine that had been allocated earlier. Unless an unforeseen emergency arises, vaccine will be distributed through normal commercial channels.

FEDERAL PROGRAM STILL EFFECTIVE

The Federal program grants to states to help finance Salk inoculations continues without change, and the priority age groups in this category still apply.

Dr. Ralph E. Dwork, director of the Ohio Department of Health, announced this priority as follows: "The current priority includes children between the ages 1 through 19 and pregnant women. It is recommended that everyone in this group who has had only one injection of poliomyelitis vaccine be given a second, with preference extended to those 15 and under and pregnant women. It is further recommended that where it is felt necessary, one injection be offered to those under 1 year of age."

The Ohio Department of Health will continue to purchase a proportion of available vaccine to

be distributed through local health departments under the Federal grant program. The remainder of the supply of vaccine will go through commercial channels.

The U. S. Public Health Service is obligated by law to maintain supervision of the manufacturing methods used in producing vaccine and inspection of finished product. The USPHS also will continue to notify the Ohio Department of Health when manufacturers' shipment lots are ready so that the Department can purchase necessary supplies for distribution to local health departments.

INCIDENCE IN OHIO

The polio season was sufficiently advanced early in August to draw some interesting comparisons on the incidence of poliomyelitis in the state, but not to formulate definite conclusions.

Through the 32nd week of 1956 there were 165 cases of poliomyelitis in Ohio reported to the Ohio Department of Health. For the same period of 1955 there were 447 cases.

Of the 165 cases reported, 56 were paralytic. Of the number of cases reported in 1956, only 25 had received the Salk vaccine, and in no case more than one shot. Only 5 in the group of those who had one shot were paralytic. There were only two deaths reported in the state from polio and neither of the persons had had vaccine.

Some interesting comparisons are shown by the number of polio cases reported during the 32nd week respectively of the five years 1952-1956. (This year the 32nd week is August 5-11.) For the corresponding week of each of these years, the number of cases reported was as follows: 1952—245 cases; 1953—195 cases; 1954—133 cases; 1955—112 cases, and 1956—34 cases.



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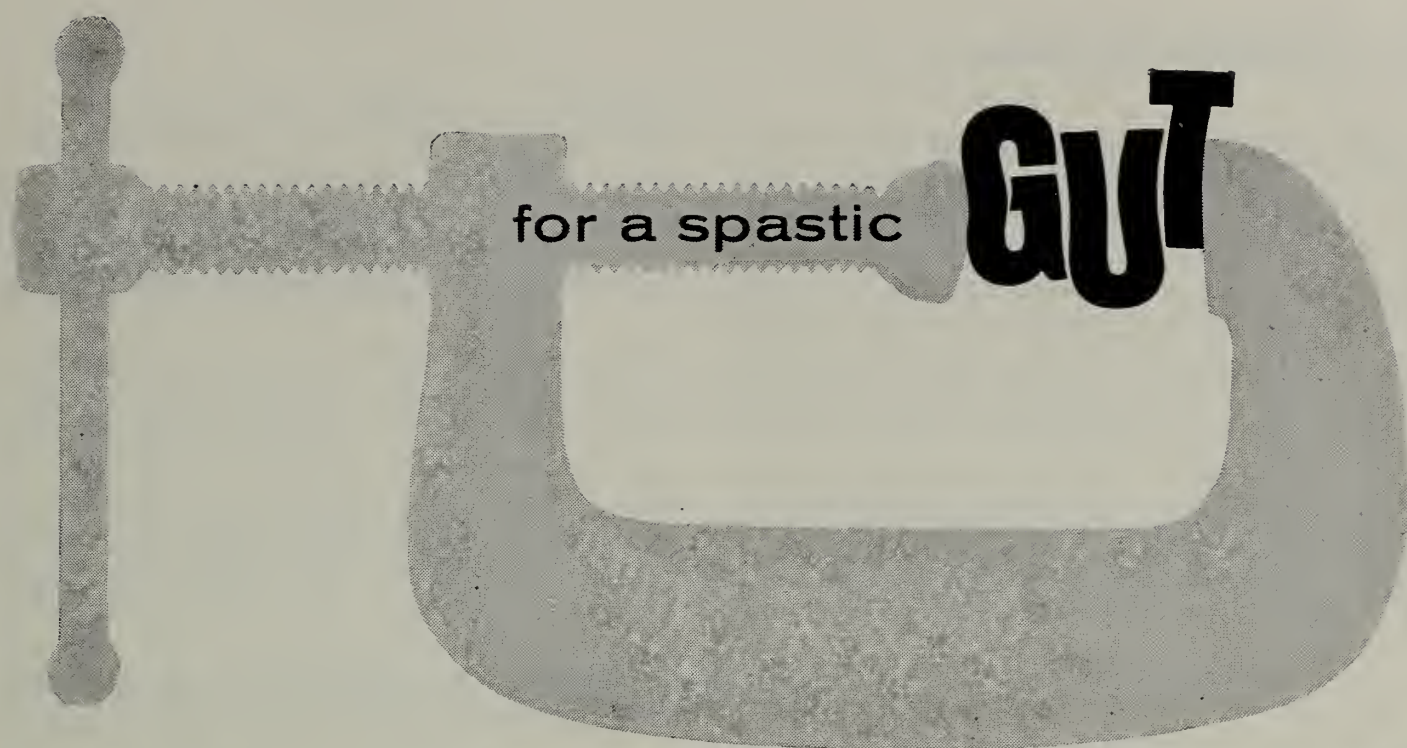
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In Memoriam . . .

Wilfred E. Allyn, M. D., Shaker Heights; Cleveland-Pulte Medical School, 1903; aged 79; died July 12; member of the Ohio State Medical Association and the American Medical Association. Before he moved to Cleveland in 1917, Dr. Allyn practiced in Chardon, where he served several years as a councilman. He continued to maintain connections there during his stay in Cleveland. Dr. Allyn was formerly chief of staff of Huron Road Hospital and for a time chief of the pediatric department there. Among organizations in which he held memberships was the Masonic Lodge. Survivors include his widow; two sons, one of whom is Dr. Wilfred E. Allyn, Jr.; a sister and a brother.

Roscoe R. Bond, M. D., Delaware; Medical College of Ohio, Cincinnati, 1897; aged 83; died July 17; member of the Ohio State Medical Association through 1947, recipient of the OSMA 50-Year Award; honorary member of the Montgomery County Medical Society. Dr. Bond practiced his profession for more than a half century in the Dayton area. He was a member of several Masonic bodies, the Presbyterian Church, and was a veteran of World War I. Two daughters survive.

Charles C. Casto, M. D., Shaker Heights; Western Reserve University School of Medicine, 1921; aged 68; died July 1; member of the Ohio State Medical Association and the American Medical Association. Dr. Casto had been a practicing physician in the Cleveland area for 33 years. He was a member of Phi Sigma Kappa and Alpha Kappa Kappa. Surviving are his widow, a son and a sister.

Gertrude Felker, M. D., Dayton; University of Michigan Medical School, 1901; aged 83; died July 22; member of the Ohio State Medical Association and the American Medical Association; recipient of the OSMA 50-Year Award. Dr. Felker was a pioneer in many phases of her professional work. She was one of the early women physicians of the nation, opening a practice in Dayton in 1903 after an internship with the New England Hospital for Women and Children in Boston. An ardent worker with the milk commission, she is credited with establishing model sanitary regulations in the Dayton area, and in 1954 she was voted "Woman of the Year" by the Dayton Business and Professional Women's Club. Other organizations in which she was active included the College Women's Club, the Presbyterian Church and the YWCA. A nephew survives.

Francis J. Gannon, M. D., Cleveland; St. Louis University School of Medicine, 1937; aged 47; died July 9. Dr. Gannon had been a practicing

physician in the Newburgh area of Cleveland for about 20 years. He was a member of the Catholic Church, Phi Chi, the University Club and the Knights of Columbus. Surviving are his widow, six children, a brother and four sisters.

Benjamin H. Moffatt, M. D., Shelby; Medical College of Virginia, 1915; aged 67; died July 28; member of the Ohio State Medical Association and the American Medical Association. Dr. Moffatt had been a practicing physician in Shelby since 1919 and local health commissioner for 22 years. In addition to his professional work, he was active in the Rotary Club, the Lutheran Church, and several Masonic bodies. Survivors include his widow, a son, Dr. Robert E. Moffatt of Mansfield, and two sisters.

L. Harry Newburg, M. D., Valley Center, Calif.; Harvard University Medical School, 1908; aged 73; died July 17; former member of the Ohio State Medical Association; member of the American College of Physicians and the American Society for Clinical Investigation; diplomate of the American Board of Internal Medicine. A native of Cincinnati, Dr. Newburg practiced there for a number of years before leaving for the University of Michigan where he became head of the clinical research department. He retired in 1951 as professor emeritus in the field of clinical investigation. Surviving are his widow, a son and a sister.

Frederick C. Smith, M. D., Marion; Universities of Frankfurt, Germany, and Vienna, Austria; aged 72; died July 16; member of the Ohio State Medical Association and the American Medical Association. A practicing physician for many years in Marion, Dr. Smith founded the Smith Clinic in that city in the mid-1920's. Active in civic affairs, he served as mayor of Marion and as Eighth District Congressman for several terms. He was a member of the Methodist Church. Surviving are his widow; two sons, Dr. Frederick G. Smith and Dr. Philip W. Smith, both of Marion; two brothers, Dr. William P. Smith, Columbus, and Dr. Dorian Smith, New Philadelphia; also two sisters.

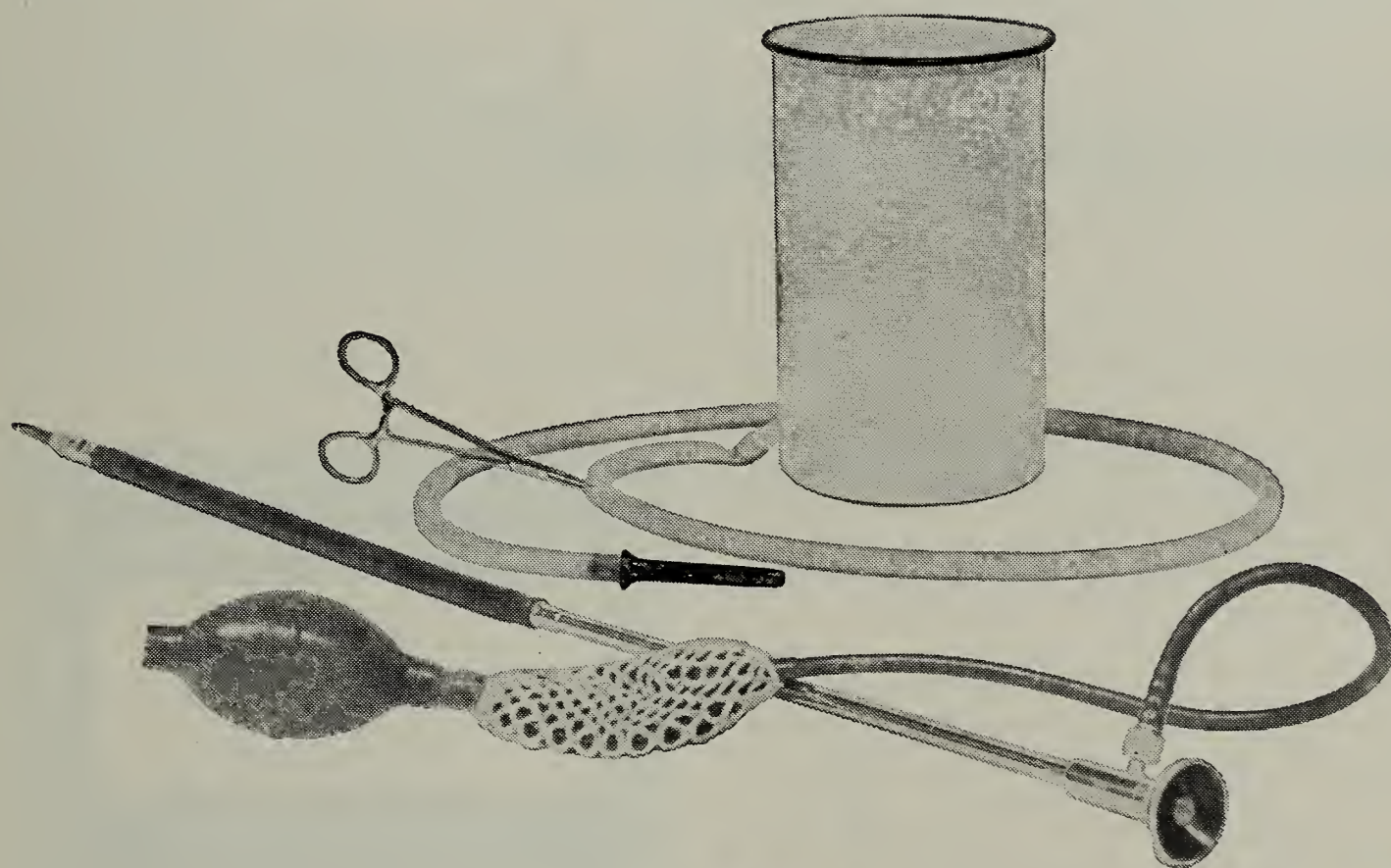
Harry J. Stoll, M. D., Wooster; Rush Medical College of the University of Chicago, 1900; aged 80; died July 22; member of the Ohio State Medical Association through 1946; member of the Wayne County Medical Society; Fellow of the American College of Surgeons; recipient of the OSMA 50-Year Award. A native of nearby Orrville, Dr. Stoll practiced most of his life in Wooster, extending his work into hospitals of neighboring towns. For many years he operated the Wooster Hospital, and for a good part of

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his career lectured in surgery at Western Reserve. He was a member of the Presbyterian Church. Six sons and a brother survive.

Joseph E. Svoboda, M.D., Garfield Heights; Ohio State University College of Medicine, 1928; aged 58; died July 28; member of the Ohio State Medical Association and the American Medical Association. Dr. Svoboda had been a practicing physician in the Greater Cleveland area for 27 years. During World War II he served as Captain in the Army Medical Corps. His widow and a brother survive.

Profession Represented in Move To Curb Growing Toll on Highways

Safety on the highways, a growing problem to all concerned with health and safety programs, has received double attention by two important conferences. In both instances the medical profession was represented and offered its advice and cooperation in laying the groundwork for a more practical safety program.

More than 200 Ohioans, representing nearly as many organizations vitally interested in safety, attended the Midwestern Regional Conference of the President's Committee for Traffic Safety in Chicago.

Four Ohio physicians played a part in this conference. They are Dr. Drew L. Davies, Columbus, who represented the Ohio State Medical Association; Dr. C. C. Sherburne, Columbus, president of the Columbus Automobile Club; Dr. Frank H. Mayfield, Cincinnati, chairman of the American College of Surgeons' subcommittee on crash injury prevention; and Dr. Donald M. Glover, Cleveland, director of surgery at Western Reserve University School of Medicine.

As a follow-up to this conference, Governor Frank J. Lausche called a conference of the same group of Ohio representatives on July 24, to attempt to work out a state-wide program to deal with the problem on a practical basis.

Governor Lausche outlined to the conference a proposed program to be presented to the next session of the Ohio General Assembly. The program in general would cover the following points:

A point system through which driving rights of repeater traffic offenders could be taken away. (A similar proposal failed to win approval in the 1955 Legislature);

Licensing of adult driver training schools;

Compulsory safety inspection of motor vehicles through state operations. (The Governor opposed in 1955 compulsory inspection through private garages);

Expansion of driver-training programs in high schools to include all high school students;

More driver's license examiners;

More state highway patrolmen.

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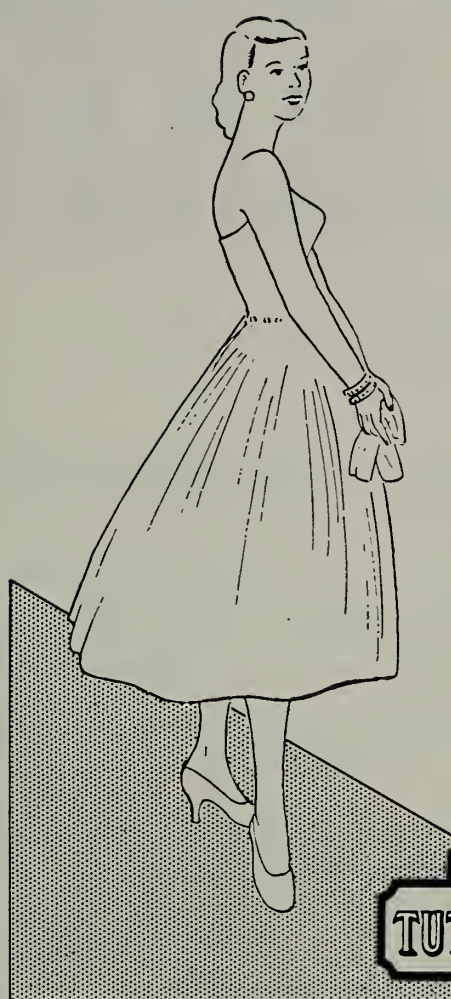
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Activities of County Societies . . .

ADAMS

The Adams County Medical Society met at West Union, July 26, with Dr. Herbert C. Boehner as guest speaker from Cincinnati. Dr. Boehner spoke on "Intestinal Obstruction."—Hazel L. Sproull, M. D., Secretary.

CUYAHOGA

The Academy of Medicine of Cleveland is co-operating with the Cleveland Academy of Pharmacy, the Cleveland Health Museum and the Cleveland Dental Society in presenting an educational display in connection with the first Family Fair to be held in the Cleveland Public Auditorium, October 21-28.

HAMILTON

The Academy of Medicine of Cincinnati will hold its annual meeting and kick-off for the season's events on September 18 at the College of Medicine Auditorium. At that time Dr. Howard D. Fabing will assume the presidency to succeed Dr. Charles A. Sebastian. Other elected officers and key persons in the organization are: Dr. George X. Schwemlein, president-elect; Dr. Warren L. Strohmenger, secretary; Dr. James R. Mack, treasurer; Dr. Earl C. Van Horn, trustee, three-year term; Dr. Virgil A. Plessinger, trustee, one-year term to fill unexpired term of Dr. Fabing; Dr. Clyde S. Roof, councilman-at-large, three-year term; Dr. Carl F. Vilter, delegate, three-year term; Dr. Richard Homan, delegate, three-year term; Dr. Robert E. Howard, alternate delegate, three-year term; Dr. Charles D. Bahl, alternate delegate, three-year term.

KNOX

The Knox County Medical Society at its July meeting approved a resolution approving the affiliation of the Knox County Mental Health Association with the Moundbuilders Guidance Center at Newark.

TUSCARAWAS

Members of the Tuscarawas County Medical Society and their families held their annual picnic meeting at the Sun Valley home of Dr. and Mrs. Burrell Russell, near New Philadelphia. Dr. Robert Rinderknecht, of Dover, was chairman of the outing committee, assisted by Dr. and Mrs. Russell and Dr. and Mrs. Benjamin Pilloff.

Later in the summer, members of the Tuscarawas County Pharmaceutical Association were hosts to members of the Medical Society at Winklepleck's Grove at Sugarcreek. Activities included golf at the Sugarcreek course.

United States hospitals cared for 21,072,521 patients in 1955, more than in any previous year, the American Hospital Association announced.

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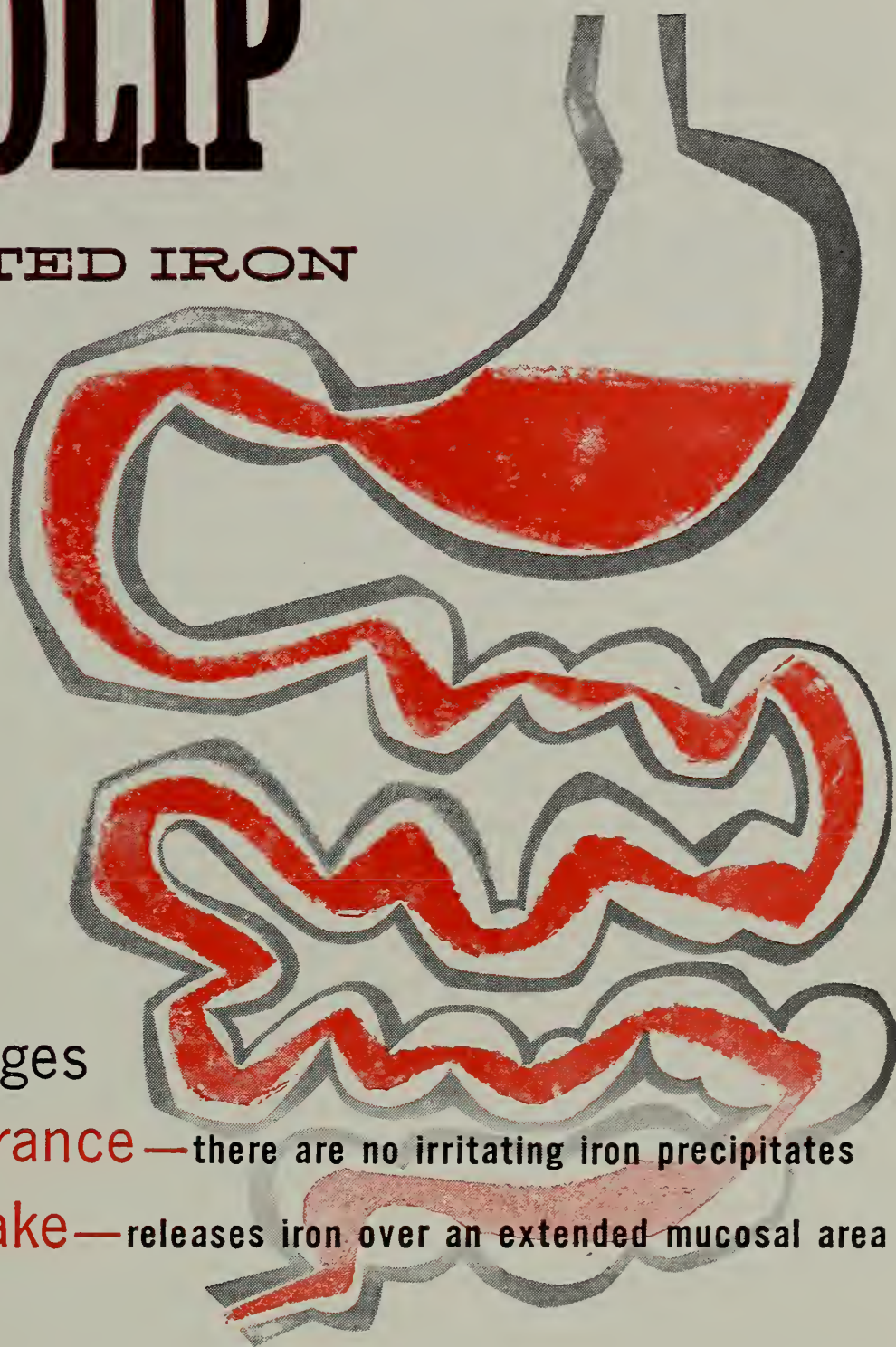
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More Gains in Insurance Coverage . . .

Increases Shown In Past Year in Number Protected for Hospital, Surgical And Medical Costs; Benefits Also High, Health Insurance Council Reports

BENEFIT payments under voluntary health insurance programs, designed to help people pay hospital and doctor bills, are running 20 per cent higher so far this year than in 1955, the Health Insurance Council has announced, in releasing the findings of its annual survey of the extent of voluntary health coverage in the United States. In 1955 such payments amounted to 2.5 billion dollars.

The increase in benefit payments, the Council said, reflects both the progress made by the American people in bringing their health insurance protection to more nearly adequate levels, and the continued spread of ownership.

FIGURES ESTIMATED

As of July 31, the Council estimates, some 110 million persons, an all-time high, were covered by hospital insurance, while 94 million had surgical protection, 58 million had policies that cover regular medical expenses and seven million were insured against major medical expenses.

The survey, which is made annually by the Health Insurance Council, is based upon reports of health insurance programs conducted by insurance companies, Blue Cross-Blue Shield and other health care plans.

GAINS CITED

Commenting on the advances of voluntary health insurance for the year, the report stated, "The rapid growth of hospital, surgical and regular medical expense insurance during 1955 was a continuance of truly spectacular trends that have been in progress for more than a decade." During the year, the report went on to say, the number of people with hospital insurance increased by 6.1 per cent, surgical insurance was up 7.0 per cent and regular medical expense protection made a 17.5 per cent gain. Major

medical expense insurance made the greatest advance with an increase of 138 per cent.

SOME HIGHLIGHTS

Some highlights of the Council survey at year's end are:

In addition to the 2.5 billion dollars paid in hospital, surgical and other medical benefits in 1955, the insurance companies paid 595 million dollars in benefits to people under policies designed to help replace income lost because of sickness or accident. This would bring the total benefit payments for the year to 3.1 billion dollars.

HOSPITAL COVERAGE HIGHEST

Provision for hospital care still occupied the number one place in the American health insurance program, with 59,645,000 persons holding policies from insurance companies; 50,726,000 enrolled by Blue Cross-Blue Shield; and 4,530,000 covered by miscellaneous plans. Making allowance for people protected by more than one type of insuring organization, the Council reported that 107.6 million persons are covered by hospital insurance.

Protection under surgical programs to help meet the expense of operations was provided by insurance companies to 56,645,000 persons; 39,165,000 by Blue Shield; and 4,340,000 by the other health care plans. Allowing for those with duplicate health insurance coverage, the survey finds 91.9 million persons protected against surgical costs.

MEDICAL PROTECTION GAINS

Regular medical expense insurance, providing doctor visits for nonsurgical care, accounted for 29,451,000 persons through Blue Cross-Blue Shield, while 25,031,000 were covered by insurance company programs, with 4,639,000 persons insured under the miscellaneous plans. The un-

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*Bonica, J.J.; and Backup, P.H.: Northwest Med., 54:22, Jan. 1955.

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duplicated total number of persons having regular medical expense protection is 55.5 million.

Growing public awareness of the cost of catastrophic illness, the survey further disclosed, was reflected in the sharp rise in the number of persons with major medical expense insurance. Coverage under all forms of major medical programs more than doubled during 1955. Of the 5,241,000 persons covered, 4,759,000 had protection through their place of employment with the remaining 482,000 insured through individual and family major medical expense policies.

DISABILITY COVERAGE

Completing its report on coverages, the Council stated that disability loss of income insurance covered 33,476,000 persons, including three million people who hold two or more such insurance policies. Of this number, 19,238,000 were covered under group plans and 14,238,000 persons held individual policies. The number of people who work where there is a formal sick leave payment arrangement would bring the total figure to 39,444,000 persons who are protected against loss of income.

The report, as presented by the Health Insurance Council, which is a federation of leading insurance associations, is the tenth annual review of the extent of voluntary health insurance coverage in the United States.

Licensed Through Endorsement by State Medical Board

The State Medical Board has issued licenses to practice medicine and surgery in Ohio to the following physicians through endorsement of their licenses to practice in other states. Intended residence given at time of application and medical school of graduation also are given.

April 3—George D. J. Griffin, Cincinnati, Loyola University.

June 15—Howard D. Arbuckle, Cleveland, Univ. of Pittsburgh; Douglas V. Auld, Sandusky, Univ. of W. Ontario; David S. Ayres, Springfield, Indiana Univ.;

James B. Ball, Bellevue, St. Louis Univ.; Caesar S. Bassette, Jr., Cincinnati, Howard Univ.; Bernard J. Begley, Gallipolis, Creighton Univ.; David L. Benninghoff, Cleveland, Columbia Univ.; James A. Benz, Lima, Indiana Univ.; J. Edward Book, Willard, Univ. of Pennsylvania; Justine Borchers, Dayton, Northwestern Univ.; Norman S. Brandes, Columbus, Univ. of Tennessee; Ronald G. Burrows, Xenia, Baylor Univ.;

Alfred L. Coles, Hamilton, Meharry Univ.; Paul E. Cooley, Swanton, Univ. of Michigan; Esque Crawford, Cleveland, Howard Univ.; Ernest B. Cunningham, Middletown, Tulane Univ.; James S. Dean, Cincinnati, Univ. of Pennsylvania; Leo T. Delaney, Jr., Cleveland, Georgetown Univ.;



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*Moyer, J. H., and others:
J. Chronic Dis. 2:670, 1955.

Nicholas Demmy, Cleveland, Univ. of Maryland;
Robert J. Duran, Columbus, Univ. of Oklahoma;

Robert H. Ebert, Cleveland Hts., Univ. of Chicago; Alvin A. Freehafer, Cleveland, Hahnemann Univ.; Aubrey R. Furnas, Jr., Akron, Indiana Univ.; Thomas G. Geoghegan, Cleveland, Univ. of Buffalo; John A. Goodno, Jr., Columbus, Med. Col. of Virginia; Robert C. Griggs, Cleveland, Harvard Univ.;

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Joseph J. Larkin, Dayton, St. Louis Univ.; James E. Leibold, Dayton, St. Louis Univ.; Edward J. Leschansky, Dayton, St. Louis Univ.; Charles Long, II, Cleveland, Univ. of Pennsylvania; Joseph F. Lydon, Lakewood, Temple Univ.;

Arthur J. McAdams, Jr., Cincinnati, Johns Hopkins Univ.; Morris E. McClure, Columbus Grove, Indiana Univ.; Cyril E. McEnany, Cleveland, State Univ. of Iowa; Joseph S. McKell, Chillicothe, Univ. of Colorado; Robert V. McMahon, Cleveland, New York Med. College; Thomas V. McManamon, Cleveland, St. Louis Univ.; Jack G. Miller, Alliance, Emory Univ.; Albert J. Modlin, Akron, Geo. Washington Univ.; James G. Morgan, Columbus, Meharry Univ.; Paul D. Murphy, Bellaire, Tufts; Arthur R. Nelson, Columbus, Johns Hopkins Univ.; Richard J. Noveroske, Akron, Indiana Univ.; Thomas K. Oliver, Jr., Columbus, Harvard Med. School; Donal D. O'Sullivan, Toledo, Stritch Med. College;

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Bernard Rapoport, Toledo, Harvard Univ.; Henry Rappaport, Cincinnati, Univ. of Vienna; John T. Reeves, Cincinnati, Univ. of Pennsylvania; Alan Raftery, Canton, St. Louis Univ.; Norman L. Rose, Dayton, St. Louis Univ.; Howard M. Rosenblatt, Toledo, Chicago Univ.; Eric F. Routley, Dayton, Univ. of Toronto; Jack H. Rubinstein, Cincinnati, Harvard Med. School;

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GYNECOLOGY & OBSTETRICS—Obstetrics & Gynecology, three weeks, Oct. 22. Vaginal Approach to Pelvic Surgery, one week, Oct. 15.

MEDICINE—Electrocardiography & Heart Disease, two-week basic course, Oct. 8; one week advanced course, Sept. 17. Internal Medicine, two weeks, Sept. 24. Gastroenterology, two weeks, Oct. 22. Dermatology, two weeks, Oct. 15. Cardiology (Pediatric), two weeks, Nov. 5.

RADIOLOGY—Diagnostic X-Ray, two weeks, Nov. 26. Clinical Uses of Radioisotopes, two weeks, Oct. 8.

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Robert S. Sobocinski, Columbus, Univ. of Buffalo; Elbert L. Spencer, Akron, Meharry Univ.; Clarence J. Stechschulte, Jr., Lima, St. Louis Univ.; Julian G. Suhrer, Jr., Painesville, Emory Med. School; Betty S. Sutherland, Cincinnati, Univ. of Pennsylvania; James M. Sutherland, Cincinnati, Univ. of Chicago;

Robert Tobe, Toledo, Univ. of Michigan; Edwin M. Todd, Jr., Cleveland, Hahnemann Med. College; William L. Vogt, Upper Sandusky, Univ. of Oklahoma; Thomas W. Watkins, Tiffin, Jefferson; Kurt J. Wegner, Youngstown, Univ. of Buffalo; Herbert L. Weininger, Univ. of Amsterdam; Leon R. Williams, Dayton, Meharry; William A. Winslow, Toledo, Univ. of Michigan; Gilbert F. Young, Columbus, Medical College of South Carolina.

Applications for Sears-Roebuck Loans Now Being Received

The Sears-Roebuck Foundation has announced that it is now accepting applications for loans from its Revolving Assistance Fund to be made during the last half of 1956. Applications received before October 1 will be acted upon by December 15.

The purpose of the fund, which was established a year ago, is to make loans to physicians desiring to establish or improve medical facilities in areas where the medical care is inadequate. It is administered by the Sears-Roebuck Foundation in cooperation with the American Medical Association, and evaluation of all applications is conducted by a Medical Advisory Board of physicians appointed by the Board of Trustees of the AMA.

The plan involves a ten-year, non-secured loan ranging from zero to six per cent interest, depending upon the rapidity of repayment. So that the Revolving Fund may grow, all repayments, principal and interest, go into the fund for future loans. The cost of administration is met by another Foundation grant.

During the past year, 22 loans have been made, affecting 33 physicians in 13 states. Loans have ranged from \$3,000 to \$25,000 and total loans amount to \$179,500.

Additional information can be secured from the Headquarters Office of the Ohio State Medical Association, or the Sears-Roebuck Foundation 3333 Arthington Street, Chicago.

The AMA's Council on Industrial Health has announced plans are being made to hold the next Congress on Industrial Health February 3-6 at the Biltmore Hotel, Los Angeles.

INDEX TO ADVERTISERS

Abbott Laboratories	904 - 905
American Meat Institute	925
Ann Arbor School	1001
Appalachian Hall	922
Ayerst Laboratories, Inc.	996
Baker Laboratories, Inc.	915
Bayer Company, The., Div. of Sterling Drug Co., Inc.	914
Breon, Geo. A., & Company	923
Burroughs Wellcome & Co. (U. S. A.) Inc.	907, 919, 975
Ciba Pharmaceutical Products, Inc.	991
Cincinnati Sanitarium	906
Cook County Graduate School of Medicine	1001
Davies, Rose & Co., Ltd.	987
Endo Products, Inc.	924
Flint, Eaton & Company	997
Foot-so-Port Shoe Company	1000
Geigy Pharmaceuticals, Inc.	967
General Foods Corporation (Sanka)	902
Harding Sanitarium	920
Hoffmann-LaRoche, Inc.	Insert between Pages 936 - 937
Knox, Chas. B., Gelatine Co., Inc.	903
Lakeside Laboratories, Inc.	897, 982, 1000
Lederle Laboratories	901, 958 - 959
Liebel-Flarsheim Co.	913
Lilly, Eli, and Company	928
Loma Linda Food Company	912
Luzier's, Inc.	969
Magnetic Springs Foundation	983
Mallard, Inc.	979
McMillen Sanitarium	920
Medical Protective Company	994
Merck Sharp & Dohme	916 - 917
Neil Training School	1003
New York Polyclinic Medical School	983
Parke, Davis & Company	1004 and Inside Back Cover
Pfizer, Chas. & Co., Inc.	973, 989
Pogue, Mary, School, Inc.	990
Quincy X-Ray & Radium Lab.	1003
Rocky Glen Sanatorium	998
Sawyer Sanatorium	918
Schering Corporation	Insert Between Pages 912-913; Pages 926-927, 980, and Insert Between Pages 980 - 981
Scroggins, Clayton L., Associates (Medical-Dental Management)	991
Searle, G. D. & Company	965
Smith, Kline & French Laboratories	Back Cover
Squibb, E. R. & Sons, Division of Olin-Mathieson Chemical Corporation	911
Stoneman Press	995
Tutag, S. J. & Company	995
Upjohn Company	921
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"My back
was so tight
I couldn't
even get on
and off
the bus;
now I can
climb stairs."

"Take it
from me,
you should
be glad
you saw him
early in the
game so he
could do
some good."

"Good?—
why, he's
got me doing
exercises
I haven't done
in years."

"I hope
he helps
my knee
that quick."



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The Physician's Bookshelf

By JONATHAN FORMAN, M. D.

Physical Education for Girls and Women, from the Department of Physical Education of Flora Stone Mather College, Western Reserve University, (\$3.95, paper. *Prentice Hall, Inc., New York 11, N. Y.*). Here physical growth and development are treated as part of the total educational process. It emphasizes that these factors are closely allied with academic progress. The book will make the subject more meaningful to students, and may stimulate a desire to continue recreational activities after they have left school.

Food Poisoning, by G. M. Dack, Ph. D., M. D., (\$6.00. 3rd edition. *University of Chicago Press, Chicago 37, Illinois*). Since the appearance of the second edition, much progress has been made involving all classes of causative agents in this field. The problem of chemical additives to foods has increased the necessity of emphasis on our law enforcement agencies. New knowledge has been added in this book on plant and animal poisons in foods. The bacterial food poisoning section has been extensively revised and enlarged.

Our Smallest Servants, The Story of Fermentation. (Apply. *Chas. Pfizer & Co., Inc., Brooklyn 6, N. Y.*). This is the story of the microbial underworld. It is an attractive book with authentic illustrations, which make clear the story of our antibiotics.

Introduction to Operating-Room Technique, by Edna C. Berry and Mary L. Kohn, of Western Reserve University. (\$4.00, paper. *The Blakiston Division, McGraw Hill Book Co., New York 18, New York*). The material in this text is the outgrowth of the co-authors' experience in the operating room, one as an instructor of students, and the other as head operating nurse. The aim of the book is to facilitate the nurse's study of aseptic technique and the care of the patient in the operating room.

Allergy in Childhood, by Jerome Glaser, M. D., (\$12.00. *C. C. Thomas Publisher, Springfield, Ill.*). This is one of the American Lectures series in allergy, edited by Max Samter, M. D. Much of the material is new to any book discussing pediatric allergy. For instance, the discussion of insect bites and stings, physical allergy, eosinophilic pneumopathy, the allergic-tension-fatigue syndrome, the management of the child with chronic asthma, the steroids in the treatment of allergic disease, diseases caused by pollen other than rose colds and hay fever, anaphylactoid purpura, allergies to drugs and vaccines, the collagen diseases. Also discussed are a great variety of other disorders with allergic or simulated allergic

symptoms. This book should prove a real help to the pediatrician, the pediatric allergist, and to all the other practitioners who see children, at least 10 per cent of whom are allergic.

Historia De La Optalmologia En Venezuela Hasta 1955, by Jose Manuel Espino, M. D., Volumes Nos. 5 and 6 of the *Review of the Venezuelan Society of the History of Medicine, Caracas, Venezuela*. This is a comprehensive review of the history of ophthalmology up until 1955.

The Health Finder, by J. I. Rodale and Ruth Adams, (\$5.95. *Rodale Books, Inc., Emmaus, Pa.*). This book is devoted to prevention of disease as seen through the eyes of an enthusiastic layman. Here we find the names of various diseases, and alongside these names we find suggestions on how to prevent them, and how diet might improve the individual. While this book will not meet the approval of the orthodox modern nutritionists in many places, it is questionable whether anyone could be harmed by following the recommendations made. Indeed it would probably improve the health of most people.

To Define True Madness, Common Sense Psychiatry for Lay People, by Henry Yellowlees, M. D., (\$.65. *A Pelican Book, Penguin Books Inc., Baltimore, Md.*). The author is a distinguished Scottish psychiatrist. He has attempted in this book to give nonmedical readers a fuller and clearer understanding of a few of the disorders with which psychiatry deals—"delusions," "inferiority complex," "anxiety neuroses," "suggestion," "hypnotism" and the pathology of psychiatry.

The Interpretation of the Unipolar Electrocardiogram, by Gordon B. Myers, M. D., (\$4.75. *C. V. Mosby Co., St. Louis 3, Mo.*). This is an outgrowth of previous lectures prepared to supplement the graduate course in electrocardiography given at Wayne University for many years. It attempts to give an organized presentation of the interpretation of the unipolar electrocardiogram.

The Pediatric Years, by Louis Spekter, M. D., M.P.H., (\$12.50. *C. C. Thomas, Publisher, Springfield, Ill.*). This is a guide in pediatrics for workers in health education and welfare by the director of the Bureau of Maternal and Child Hygiene of the Connecticut State Department of Health. To those for whom this is intended, it is indeed a valuable handbook.

Nurse With Wings, by Adelaide Humphries, (\$2.50. *An Avalon Book, Bouregy & Curl, Inc., 22 E. 60th St., New York, N. Y.*). The author
(Continued on Page 1016)



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The Postural Complex: Observations as to the Cause, Diagnosis, and Treatment, by Laurence Jones, M. D., (\$9.75. *C. C. Thomas, Publisher, Springfield, Ill.*). This book is a unique addition to the extensive literature on the relation of posture to neuralgic pain in various parts of the body. It reports the studies and investigations of a competent orthopedic surgeon over a period of more than 15 years.

Splenin "A" in Rheumatic Fever, the Testing of Splenin "A" as an Anti-Inflammatory Agent, by A. F. Coburn, M. D., Lucille Moore, M. D., Judith Wood, M. D., and Mary Roberts, R. N., (\$3.75. *Charles C. Thomas, Publisher, Springfield, Ill.*). This is a monograph prepared in the Rheumatic Fever Research Institute at Northwestern University. It gives laboratory and clinical data, and detailed case histories, with one to three year follow-up reports.

Clinical Analgetics, by E. G. Gross, M. D., and M. J. Schiffrin, Ph. D., (\$3.00. *Charles C. Thomas, Publisher, Springfield, Ill.*). This monograph gives us a concise, practical guide on analgetics for the general practitioner, dentist, pharmacist, and dental student. It is a description of the more commonly employed agents, dosage, forms, toxicity, the indications and counterindications. These analgetic agents are defined as those materials which, when administered, provide relief from pain by means other than the reduction or removal of the causative factor.

The Pathogenesis of Poliomyelitis, by Harold K. Faber, M. D., (\$5.00. *Charles C. Thomas, Publisher, Springfield, Ill.*). This book explains the modus operandi of poliomyelitic infection. It is extremely helpful in diagnosis, especially in the early, pre-paralytic stages. It explains both the positive and negative aspects and is therefore helpful in making diagnosis and ruling the disease out in suspected cases.

Backache, by Frank R. Ober, M. D., (\$3.00. *Charles C. Thomas, Publisher, Springfield, Ill.*). Here is presented a discussion of a universal problem. There is no single answer to the complaint, since the condition is only a symptom of some underlying condition which may or may not be directly connected with the spine itself. The author aptly reports that for 50 years "sacro-iliac slip" or "disk" has been the wastebasket into which most back troubles were dropped. The diagnosis of "ruptured disk" is rapidly replacing

"sacro-iliac," unfortunately with as little help to the patient in pain as was the earlier diagnosis. The author insists that the lame back is due to a distortion of the normal curves of the spine and that this is primarily responsible for the pain. Until this distortion is corrected, the patient will be subject to recurrent attacks, even when as definite a cause as a ruptured disk has been removed.

Why Patients See Doctors, a report of the Washington Sickness Survey, by Blair M. Bennett; Kathleen White; L. E. Powers, M. D., and Seymour Standish, Jr., (\$4.50. *University of Washington Press, Seattle, Washington*). This was prepared in cooperation with some ten private agencies in the State of Washington, as well as the State Health Council and the School of Medicine. The researchers received the full cooperation of the medical profession, in 1953, on four Tuesdays spaced at three-month intervals, the list of all patients seen, together with their diagnoses. This book contains a tabulation of the results of more than one-third of the state's physicians, and will take its place alongside the relatively few studies in this field to show the relative importance of the various special fields of medicine in terms of numbers, and therefore in terms of dollars.

Joint Ligament Relaxation Treated by Fibro-Osseous Proliferation, by George Stuart Hackett, M. D., F. A. C. S., of Canton, Ohio. (\$4.75. *Charles C. Thomas, Publisher, Springfield, Ill.*). The emphasis is placed on low-back disability, trigger point pain, and referred pain. It is, in fact, a presentation of ligament retardation as the cause of most of our back pain and disability, and more referred pain in the lower extremities than any other entity. The book has been written so as to enable the reader to successfully carry out the diagnosis and treatment.

A Cure for Serpents: A Doctor in South Africa, by Alberto Denti di Pirajno, (\$4.00. *William Sloane Associates, New York 16, N. Y.*). The author, a sophisticated, compassionate man with a great sense of humor—spent 20 years in North Africa, practicing medicine. He is one of the few Europeans to be completely accepted in the native society of North Africa—in pasha's palace, beggar's cave, or rebel's tent. The Duke of Pirajno has a natural flair for description and his observant eye has harvested the color and detail of these strange places. Much of what he reports is strong meat.

Textbook of Operative Surgery, by Eric L. Farquharson, M. D., (\$15.00. *E. & S. Livingston, Ltd. Edinburgh*; United States distributor: *Williams & Wilkins Co., Baltimore 2, Md.*). This is the work of one man, a one-volume work from the viewpoint of a general surgeon. It is designed to present the whole subject of operative surgery in balanced perspective.

The Ohio State Medical Journal

Published under the direction of The Council for and by the members of The Ohio State Medical Association, a scientific society, non-profit organization, with a definite membership, for scientific and educational purposes.

Vol. 52

October, 1956

No. 10

JONATHAN FORMAN, M. D., *Editor*

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Treatment of the Common Forms of Arthritis: Panel Discussion*

ROBERT M. STECHER, M. D., Cleveland, Moderator

PANEL discussions on problems of current interest, in which questions presented by the audience are answered by men experienced in the field enjoy a great popularity at medical meetings. They not only afford an opportunity for the practicing physician to gain the latest knowledge from specialists in the subject but they offer the specialist an opportunity to hear about questions most puzzling to the doctor called upon to treat patients. Such a Panel Discussion on the Problems of Arthritis, held at the Ohio State Medical Association meeting in Cleveland, April 12, 1956, will be summarized here. No transcript was made but the moderator has attempted to present the views if not the words of the Panel Members on the questions answered and he has taken the liberty of commenting on the questions which could not be answered because of limitation of time.

Fifty questions were submitted. By grouping and combining them it was possible to answer 20 of them.

STEROIDS IN THE TREATMENT OF RHEUMATIC ARTHRITIS

Eight questions dealt with the steroids, their role in the treatment of rheumatoid arthritis, the indications for further use, their employment in combination with each other or with salicylates, their dangers and their effect on sexual function. It was agreed that the steroids are powerful drugs for good and for evil, that the effects of different

Members of Panel:

Nathan R. Abrams, M. D., Cincinnati
William S. Clark, M. D., Cleveland
Roger Q. Davis, M. D., Akron
Norman O. Rothermich, M. D., Columbus
Ralph Wolpaw, M. D., Cleveland

steroids are similar to each other but differ in detail from drug to drug and from patient to patient.

The panelists agreed that steroids should only be used after a reasonable trial with simple methods and should be added to rather than substituted for conservative treatment. They should be used in large enough doses to produce a partial clinical remission but in small enough doses to avoid or delay contraindicating complications. There seems to be no logical reason for using ACTH at the same time or intermittently with the cortisone-like drugs. The danger of stopping or reducing the drugs in the face of stress situations, such as elective or emergency operations, accidents or infections was emphasized.

The necessity for continuous close clinical surveillance by the doctor to detect changes in blood pressure, sugar tolerance and water balance and the control of the dose to avoid hirsutism, Buffalo hump and striae of the skin and osteoporosis were also mentioned. The drugs are suppressive rather than curative because the

*Presentation at General Session, April 12, 1956, Annual Meeting, Ohio State Medical Association. No transcript was made. This account was prepared by the moderator and it was submitted to each of the panelists for their corrections and suggestions.

disease has been observed to progress despite their use.

In most cases modest doses are effective. Complications will be avoided or delayed if the dose can be limited to 50 mg. per day of cortisone, 40 mg. per day of hydrocortisone and 10 to 15 mg. of prednisone or prednisolone. The latter drugs seem to have less sodium salt retaining effect but are thought to be more likely to produce osteoporosis or to activate or produce gastric ulcers. Anti-ulcer therapy is sometimes given with these drugs as a preventive measure. The combination of steroids with a salicylate, the so called "super aspirin" is not looked upon with favor. Both drugs must be individually administered in the proper dosage to get the best effect and combining them in a constant proportion is illogical and can be dangerous.

GOLD

There were five questions about gold. Gold therapy is still used in many clinics. With small doses and careful supervision toxic symptoms, though occurring in 30 to 40 per cent of the cases, are not serious and can now be successfully combated. The effects of gold are slow to appear but remissions following the use, although not permanent, may last for several years. Gold is particularly indicated after conservative measures have failed and steroids have proven ineffective.

PHENYLBUTAZONE

There was lively discussion about phenylbutazone. The consensus was that it is a toxic, dangerous drug, highly overrated and which has limited value in peripheral rheumatoid arthritis, being effective in only 20 to 30 per cent of cases. It is very effective in acute attacks of gout where it should be used in large doses for short periods of time. For acute attacks it can be given in doses of 400 to 800 mg. the first dose and 100 to 200 mg. every four to six hours for several days thereafter. By this time the attack will have subsided and the drug can be stopped. For rheumatoid spondylitis doses of 100 to 200 mg. per day are usually effective and can be given with reasonable safety.

Red blood cell count and differential white blood cell counts should be made every week for one month, every other week for three months and every month thereafter in order to detect the first signs of agranulocytosis. Phenylbutazone is sometimes effective for short periods in acute exacerbation of rheumatoid arthritis.

ASPIRIN

Questions were asked about aspirin, plain, enteric coated, buffered, alone or with para-aminobenzoic acid, in the form of salicylamide and iodide-salicylate intravenously.

Aspirin and salicylates remain as the most important drugs for acute episodes in the relief of pain, soreness and stiffness, regardless of their cause. In general they are effective, harmless,

cheap and available. In an extensive and well controlled cooperative study conducted in England it was decided that aspirin was nearly as effective as cortisone in the treatment of rheumatoid arthritis. This seemed to be true under the conditions of the study but in practice some patients require more effective relief than is afforded by aspirin and require the use of steroid drugs for relief of subjective symptoms and improvement of functional performance.

Of course a few patients are sensitive to salicylates, a condition when present which seems to persist and which makes a positive contraindication to their use. Some patients have a limited tolerance for the drug. In such cases various forms of the drug consisting of enteric coated preparations of the drug or the drug combined with inhibitors or buffers can be tried. The dose and the time interval should be carefully adjusted in the hope that a tolerable and an effective regime can be developed.

Enteric coated salicylates are useful in avoiding gastric irritation but their action is delayed and often erratic, due to irregular absorption. Many combined forms of salicylate with other drugs such as para-aminobenzoic acid have been offered for sale but the panelists agreed that the advantages of such combinations were doubtful.

It was agreed that salicylates should be used to their greatest effectiveness so that the requirements for steroid therapy are reduced. In this way they can be used safely for longer periods of time.

THE SIGNS AND SYMPTOMS, AND DIFFERENTIAL DIAGNOSIS OF RHEUMATOID ARTHRITIS

Two questions were presented regarding the necessary signs and symptoms for the diagnosis of rheumatoid arthritis and the differences between rheumatoid arthritis, osteoarthritis and bursitis.

Rheumatoid arthritis is a generalized disease occurring at any age with multiple joint involvement associated with pain, soreness, morning stiffness, fatigue, lassitude, anorexia and loss of weight, these symptoms being mild or questionable in the early days. Onset is frequently but not always insidious, progress is slow and intermittent and more or less disability usually occurs after varying periods of time. Complete remissions sometimes occur years after onset but are not always recognized as such because of the joint damage, deformity, disability and crippling. Mild anemia and rapid erythrocyte sedimentation and increase in sheep cell agglutination usually occur. Radiographically the bones show demineralization and destruction of the joint surfaces.

Osteoarthritis is a disease of joints in a patient otherwise in excellent health. Most often it is limited to one set of joints, such as the fingers, the hips, the knees or the spine. Once present it lasts throughout life. Radiographically

it is characterized by loss of joint space because of diminution of cartilage, condensation of bone at the joint surfaces and spur formation at the joint edges. Minor changes like these due to old age are often mistaken for true osteoarthritis.

Bursitis is an inflammation of a bursa, usually a transient involvement with pain and tenderness over the bursa alone and joint motion limited because of pain usually from pressure of the overlying tendon.

MISCELLANEOUS QUESTIONS AND ANSWERS

The following questions were not answered by the panel but are discussed here by the moderator. Hormone treatment of non-rheumatoid arthritis is a controversial subject. It is not as a rule recommended for ordinary rheumatism or muscle stiffness by those most experienced in its use. It has had a following among practicing physicians in the treatment of fibrositis, osteoarthritis and bursitis with apparently encouraging results. It seems allowable to try it in small doses for short periods, to satisfy the patient as well as the doctor. Though there seems to be no direct evidence on the subject it seems wise to withhold steroid therapy at least during the first trimester of pregnancy because of its known effect of injuring the fetus in animal experiments.

Testosterone is used by some doctors with steroids in women in an effort to reduce demineralization. Demineralization seems to occur in direct proportion to the degree of disability and inactivity. It can be given in 5 to 10 mg. doses three times a day or by injection of 100 mg. of the depot form once monthly.

There were five questions about ultrasonic therapy, a subject on which the moderator has had no experience and is not qualified to speak. It has been shown that ultrasonic applications in large doses cause bone damage with demineralization and even fracture, nerve damage with irreparable degeneration and muscle damage. What the clinical effects are when properly administered do not seem to be definitely proven.

Psoriasis is a chronic constitutional skin disease associated in a high percentage of cases with deforming and sometimes disabling arthritis. This frequently affects the terminal joints of the fingers and can thus be confused with Heberden's nodes. In long standing cases absorption of the ends of the bones resulting in *lorgnette en main* and *lorgnette en doigt* is seen. Some authorities consider the arthritis of psoriasis as true rheumatoid arthritis in a psoriatic but there is good argument in favor of its being a specific psoriatic arthritis.

Benemid® is an effective drug for the mobilization of uric acid and is therefore used to prevent the deposition of uric acid tophi and seems to cause tophi to decrease in size or go away. It is of no value in the treatment of acute attacks of gout and it is doubtful if it prevents attacks initially. It is a relatively nontoxic drug. It is

prescribed in doses of 0.5 Gm. daily for one week, then 1 Gm. daily for one week, then 1.5 to 2.0 Gm. daily thereafter. This may increase acute attack initially for six months to a year after which attacks seem to be less common and the level of blood uric acid is depressed.

Spas have never attained the popularity or the high degree of social attractiveness in America that they have in Europe. There seems to be no specific benefit from them other than that obtained from rest and change and diet and entertainment. They are big business in Germany and France. There are many lovely hotels with attached tennis courts, golf courses, riding stables and natural hot springs throughout Europe where great emphasis is placed upon hot baths, mud packs, massage and passive exercises, diet, generous ingestion of foul-tasting mineral water, catharsis and rest. There are very nice hotels in attractive surroundings where the same service can be had in America at Hot Springs, Virginia; Saratoga Springs, New York; Hot Springs, Arkansas; and other places.

There seems to be no specific treatment for the arthritis of brucellosis other than possible antibiotics for the infection itself. Nyloxin® or cobra snake venom enjoys a mild wave of popularity at the present time although there seems to be no specific reason for its use nor evidence as to its effectiveness in organic arthritis. Hydrotherapy is useful in combatting inflammation, soreness and stiffness. It is usually used in conjunction with massage and passive and active exercise.

I know of no effective treatment for osteoarthritis of the finger joints. The enlargement is usually slowly progressive and mildly painful during the development stage. Hot soaks have been recommended with doubtful results and aspirin relieves the mild pain during the inflammatory stage.

Flexin® (or zoxazolamine) is a new antispasmodic said to be effective in rheumatism and fibrositis. It blocks the motor impulse at the synapse and thus relieves spasm and tension. It is too new to give a definite answer about it, however.

Diagnosis May Be Easily Missed When Reaction to Aspirin Occurs

In an era characterized by tension and strain, the consumption of aspirin (acetylsalicylic acid) in the United States has reached major proportions. The current annual production of this drug exceeds nine million pounds—an amount which provides an average of over 80 tablets per individual each year. Fortunately untoward reactions are rare. When they occur, the diagnosis may be easily missed in view of the benign reputation of the drug and the universality of its administration.—Count D. Gibson, Jr., M. D., Richmond, Va., and Ira G. Towson, M. D., Sea Island, Georgia: *J. M. A. Georgia*, 45:366, August, 1956.

Comparative Evaluation of Calcium Glycerophosphate As a Dietary Calcium Supplement*

ALBERT G. WORTON, THEODORE E. BYERS and JAMES M. GILLINGHAM

IN STUDYING the extent of calcification of bone in mice produced by a basic diet supplemented with various calcium compounds in equivalent amounts of calcium, calcium glycerophosphate was found to produce the highest degree of bone calcification. Other calcium compounds in decreasing order of efficiency were tricalcium phosphate, calcium lactate, dicalcium phosphate and calcium carbonate. The *in vitro* behavior of various calcium compounds through the gastrointestinal pH range was observed.

Recent trends in calcium supplementation have raised the following questions: (1) Is dicalcium phosphate an inadequate calcium supplement? (2) Are phosphorus-free calcium compounds ideal as sources of calcium? (3) Is phosphorus important for calcium retention? (4) Which of all the well-known calcium compounds is most efficient in bone development?

The increased nutritional requirements for calcium, particularly during pregnancy and lactation, have been recognized for many years and are now generally accepted.¹ Authorities maintain that an adequate calcium level by dietary means during this period is improbable.^{2,3} The type of calcium and criteria for evaluating the efficiency of various calcium compounds appear to require further study.

DISCUSSION

Dicalcium phosphate in particular has been widely administered to pregnant and lactating women. Unfortunately, according to medical reports in recent years, the administration of dicalcium phosphate has been shown to contribute to neuromuscular irritability as manifested by leg cramps in pregnant women.⁴ From these results and associated blood studies it has been generally concluded that insoluble phosphates have a depressive effect on absorption of calcium from the intestinal tract.

Other findings indicate that administration of dicalcium phosphate may not elevate the serum or the ionized calcium levels, and that it is inefficient as a calcium supplement.^{5,6} It has been shown that ingested calcium frequently is rendered soluble by stomach acid but is then precipitated by the increasing alkalinity of the intestine before absorption can occur.⁷ Some authors have reported that as little as 10 per cent of ingested calcium is absorbed.⁵

Because of poor results with dicalcium phosphate, there has been a tendency to use phosphorus-free calcium compounds. As a matter

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- Mr. Worton, Columbus, is scientific director of The Warren-Teed Products Company, Columbus, Ohio.
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- Mr. Gillingham, Columbus, is assistant scientific director of The Warren-Teed Products Company.

of fact, the lactate, gluconate and carbonate may be used to significantly raise the calcium blood level. Although neuromuscular irritability may be reduced with such compounds this does not guarantee skeletal metabolism of calcium. Indeed, the calcium may be on a one-way street to excretion. Authorities believe the level of the blood calcium to indicate only the height of the stream and not the direction of the flow.² It is also true that a calcium deficiency may exist despite a normal blood calcium, since calcium storage in the tissues may be depleted before hypocalcemia develops.⁸ Therefore, blood calcium readings cannot be accepted as proof of normal levels of tissue calcium.

The futility of attempting to increase calcium retention with phosphorus-free calcium salts alone has been demonstrated under controlled experimental conditions.⁹ A diet that permits normal deposition of calcium in the bone may be transformed to a rickets-producing diet by merely increasing dietary calcium and allowing dietary phosphorus to remain constant.¹⁰ Interestingly enough, phosphorus-free calcium salts are used to hasten the development of experimental rickets.^{11,12} The severity of the rickets produced under these conditions increases in ratio with the increasing disproportion of dietary calcium and phosphorus.

The primary purpose of calcium supplementation is to achieve calcification of tissue and this cannot be accomplished without simultaneous phosphatification.^{10,13} The failure of absorbed calcium to be used in calcification is said to be due to a low blood phosphorus level and calcium absorption is most rapid when phosphorus absorption is highest.¹⁴ Calcium fixation in the skeleton is thus dependent upon a simultaneous fixation of phosphorus.¹⁵

It is well to recall that the minimum daily

*Submitted July 20, 1956, by the Research Laboratories of The Warren-Teed Products Company, Columbus, Ohio.

requirement for phosphorus is approximately equal to that for calcium.^{16, 17} Some antirachitic substances act by elevating blood phosphorus, thus increasing calcium deposition.¹⁴ The two elements have been shown to be so closely inter-related that the utilization of one cannot be considered without that of the other.¹⁵

Because of the apparent inefficiency of some calcium compounds comparative evaluation of those commonly used obviously requires further study. Also, because of the hand in hand metabolism of calcium and phosphorus it appeared to be worth while to discover a calcium and phosphorus compound that is efficiently absorbed from the intestine and differs from dicalcium phosphate in that it does not cause neuromuscular irritability.

With this in mind, a number of calcium compounds were studied, including dicalcium phosphate, tricalcium phosphate (bone ash), calcium lactate, calcium gluconate, calcium carbonate and calcium glycerophosphate. The first five are the principal calcium supplements in use today. Calcium glycerophosphate until now had been employed mainly as a source of glycerophosphoric acid for use as a nerve tonic in debility and neurasthenia.¹⁸ The efficiency of calcium glycerophosphate as a source of calcium over the many years of its use, thus far, has gone virtually unnoticed.

Canals and his associates fed radioactive compounds to animals and followed the route of assimilation. They found that calcium glycerophosphate gave the highest bone absorption figures and was the most efficient of the calcium compounds tested.¹⁹

Lecoq developed experimental rickets with a phosphorus-free diet containing 1 per cent calcium lactate to hasten the rachitogenic effect.²⁰ Phosphorus-containing calcium compounds were required to cure the rickets in the following minimum amounts:

	Min. Amt. Needed
Calcium Glycerophosphate	0.85 Gm.
Dicalcium Phosphate	1.55 Gm.
Tricalcium Phosphate (bone ash)	2.50 Gm.

They showed the inorganic calcium phosphates to be largely wasted in contrast to the high efficiency of the organic calcium glycerophosphate.²⁰

The dosages of the various calcium compounds reflect their relative efficiencies. The U. S. P.²¹ or N. F.²² recommend the following dosages:

Calcium Glycerophosphate N. F. X	0.3 Gm. (5 grs.)
Dicalcium Phosphate U. S. P. XV	1.0 Gm. (15 grs.)
Tricalcium Phosphate N. F. X	1.0 Gm. (15 grs.)
(Technical grade is bone ash)	
Calcium Carbonate U. S. P. XV	1.0 Gm. (15 grs.)
Calcium Lactate N. F. X	5.0 Gm. (75 grs.)
Calcium Gluconate U. S. P. XV	5.0 Gm. (75 grs.)

Thus, with the greater absorptive efficiency of calcium glycerophosphate, a lesser dosage schedule than with other calcium compounds is possible.

The work of Canals and Lecoq and the official dosage recommendations for the several calcium compounds studied, indicate the superior efficiency of the glycerophosphate of calcium. The present study is designated to compare the efficiency of several commonly used calcium compounds with that of calcium glycerophosphate.

EXPERIMENTAL

In vitro experiments were performed to demonstrate the precipitation of various calcium compounds in the presence of phosphate at the pH levels prevalent in the gastrointestinal tract.

Concentrations of calcium glycerophosphate, dicalcium phosphate, calcium lactate, calcium gluconate were prepared in distilled water to contain 3 mg. of elemental calcium per milliliter. To the calcium lactate and calcium gluconate, phosphate ion was added to equal the 2.32 mg. per ml. of phosphorus concentrations of both the calcium glycerophosphate and the dicalcium phosphate. Portions of each of these solutions were adjusted through the pH range 2 to 9 with hydrochloric acid or sodium hydroxide. Figure 1 (see following page) shows calcium glycerophosphate to be soluble at all pH levels 2 through 9. Precipitation is observed at pH 3 with dicalcium phosphate, pH 4 with calcium lactate, and pH 5 with calcium gluconate.

Based on the work of others, the hydrogen ion concentration of the stomach, duodenum and ileum are pH 2, pH 6 and pH 8, respectively.^{23, 24, 25, 26}

It is noteworthy that calcium glycerophosphate overcomes the chief objection to other phosphate-containing calcium supplements in that it is soluble throughout the gastrointestinal pH range.

The wide range of solubility of calcium glycerophosphate suggests a greater efficiency of calcification in animal tissue and indicated the need for actual evaluation in this respect in comparison with other calcium compounds.

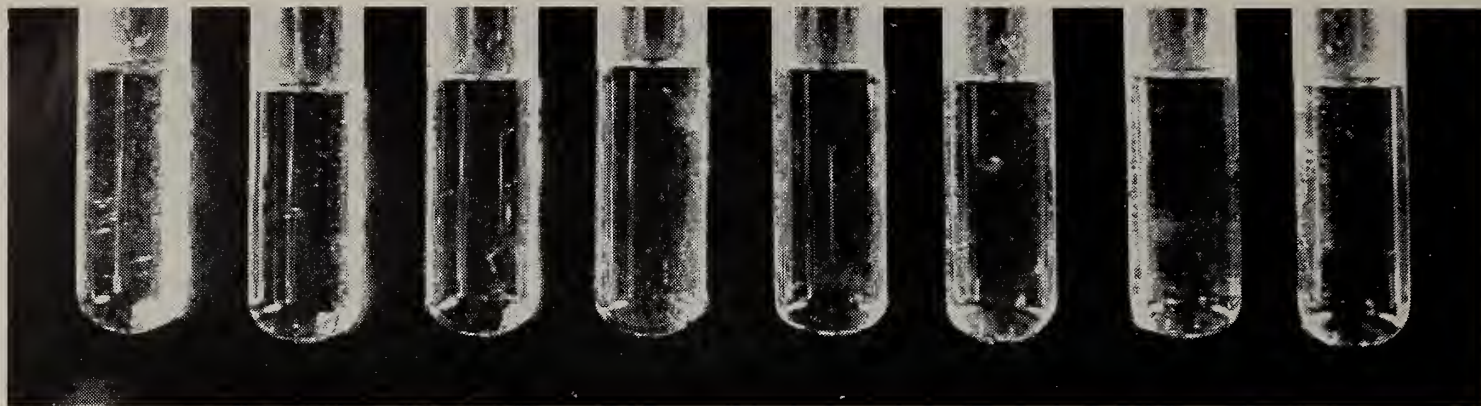
Adequate gastric acid is essential for most calcium compounds to be absorbed. Since calcium compounds are usually antacid, it is important to select one that has a minimal acid depressing action. Goodman and Gilman stress this point: "An acid reaction in the intestine promotes calcium absorption by favoring solution of calcium salts, whereas an alkaline (antacid) reaction precipitates calcium and decreases absorption."

On a strict comparative basis, 500 mg. of the various calcium salts depress acidity as follows:

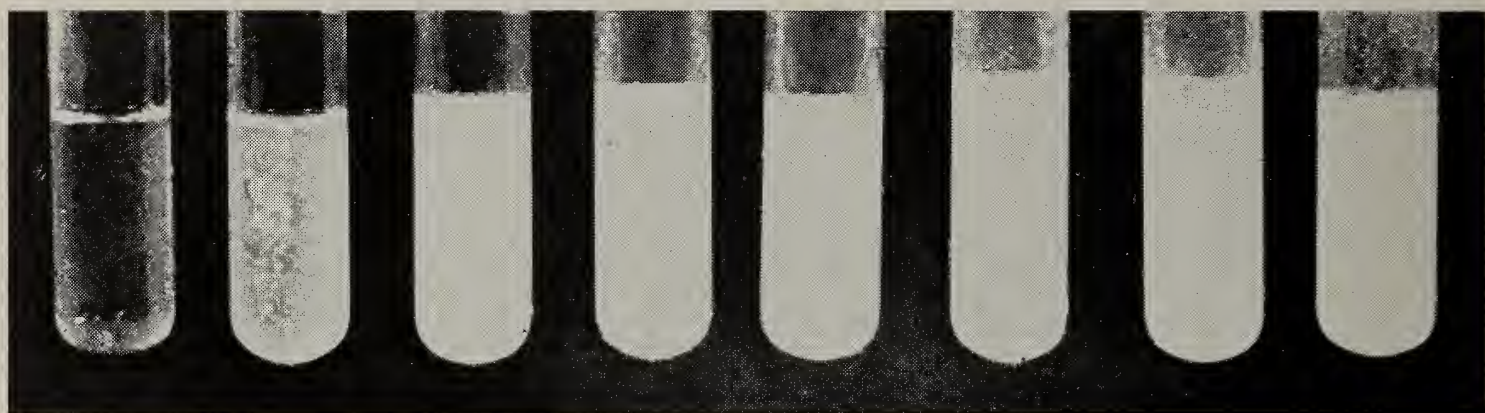
Calcium Carbonate	200.00 cc.
Tricalcium Phosphate	128.00 cc.
Dicalcium Phosphate	61.00 cc.
Calcium Lactate	55.00 cc.
Calcium Glycerophosphate ..	45.75 cc.
(Using 0.05 N. Hydrochloric Acid and Bromphenol Blue as indicator)	

Having minimal antacid properties, the glycerophosphate is an ideal calcium supplement because

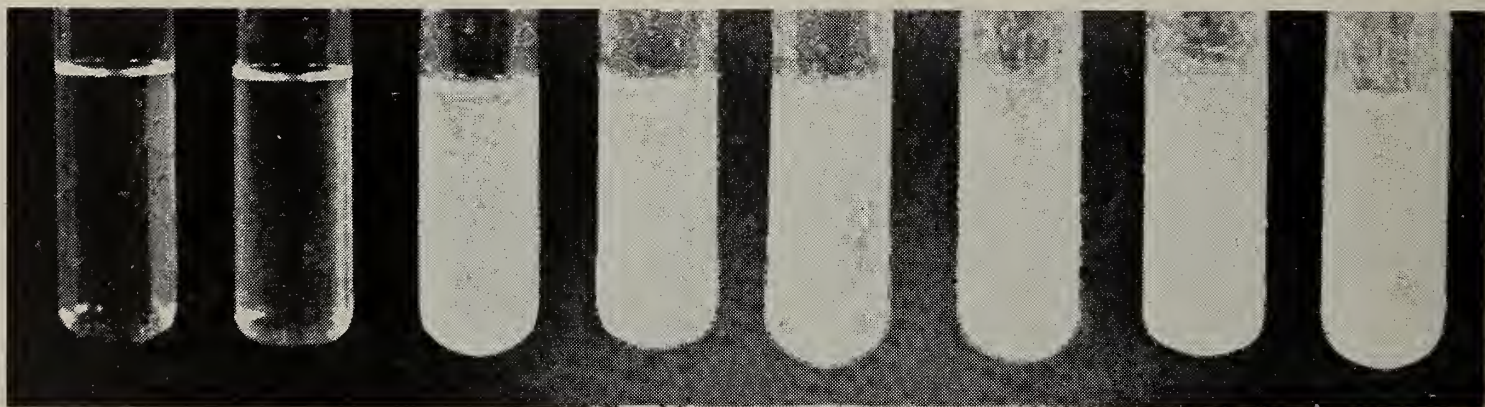
CALCIUM GLYCEROPHOSPHATE



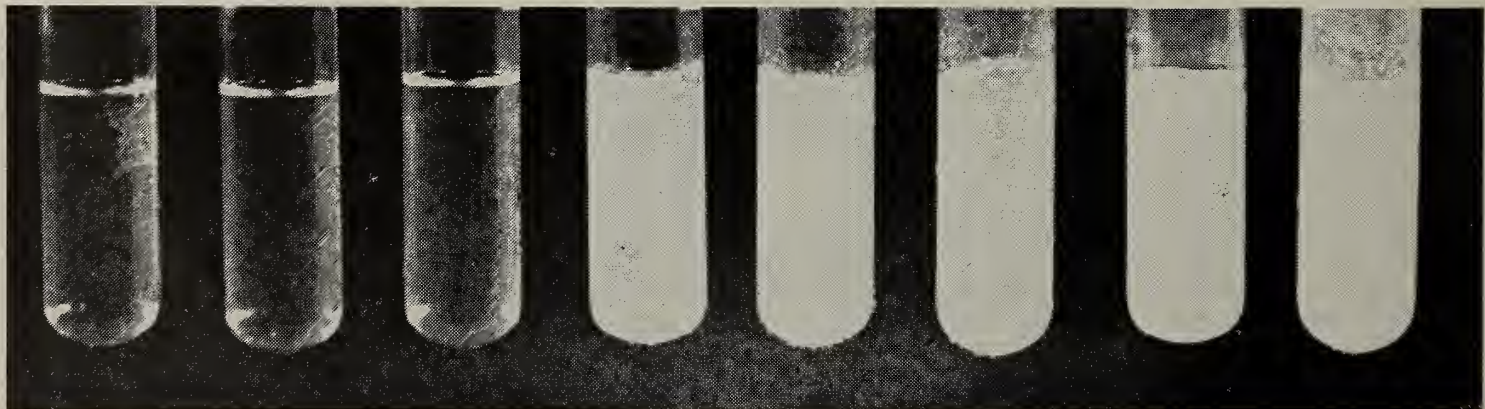
DICALCIUM PHOSPHATE



CALCIUM LACTATE WITH PHOSPHATE



CALCIUM GLUCONATE WITH PHOSPHATE



pH 2 3 4 5 6 7 8 9

NOTE: All tubes contain equivalent amounts of calcium and phosphorus.

Fig. 1. Precipitation of several calcium compounds in the presence of phosphate at various pH levels.

of the frequent acid deficiencies of both obstetric and geriatric patients.

ANIMAL STUDY*

Newly weaned female mice were separated into six groups. A diet based on the U. S. P. XIV Rachitogenic Diet No.1, but omitting calcium carbonate, was prepared. The diet consisted of the following:

Whole Wheat Ground	34%
Whole Yellow Maize	34%
Gelatin	16%
Ground Wheat Gluten	15%
Sodium Chloride U. S. P.	1%

The animals were fed this basic diet for two weeks. At the end of the two weeks, the diet was divided into six parts, one group continuing on the basic diet and different calcium compounds added to the other five parts as follows:

- A—0.5% Calcium as Calcium Carbonate.
- B—0.5% Calcium as Calcium Lactate.
- C—0.5% Calcium as Dicalcium Phosphate.
- D—0.5% Calcium as Tricalcium Phosphate (bone ash).
- E—0.5% Calcium as Calcium Glycerophosphate.
- F—Control.

The mice were fed ad libitum. Distilled water was furnished for drinking.

Samples of the leg bones (femurs and tibias) were cleaned and dried to constant weight at 110°C. The femurs and tibias were then tested for relative breaking strength by compressing each bone in a vertical position in a Strong Cobb tablet hardness tester. The dried bones were then assayed for calcium.²⁷ The percentage of bone calcium is shown in figure 2. The relative breaking strengths are shown in figure 3.

There were some striking differences in the appearance of the several groups of mice after a six week course of supplementation with various types of calcium. Those mice on the calcium glycerophosphate supplement were sleek in appearance and fully coated. The group receiving calcium carbonate exhibited extreme nervousness and excitability, marked loss of hair and scabbing, particularly on the face and tail (Fig. 4). Loss of hair around the face and back was also noted in a number of the mice receiving calcium lactate and, to a lesser degree, those receiving tricalcium phosphate. The control and dicalcium phosphate groups, though not exhibiting the sleek appearance of the calcium glycerophosphate mice, showed little or no tendency toward loss of hair or scabbing.

ANALYSIS OF RESULTS

The mice maintained on a basic diet supplemented with calcium glycerophosphate consist-

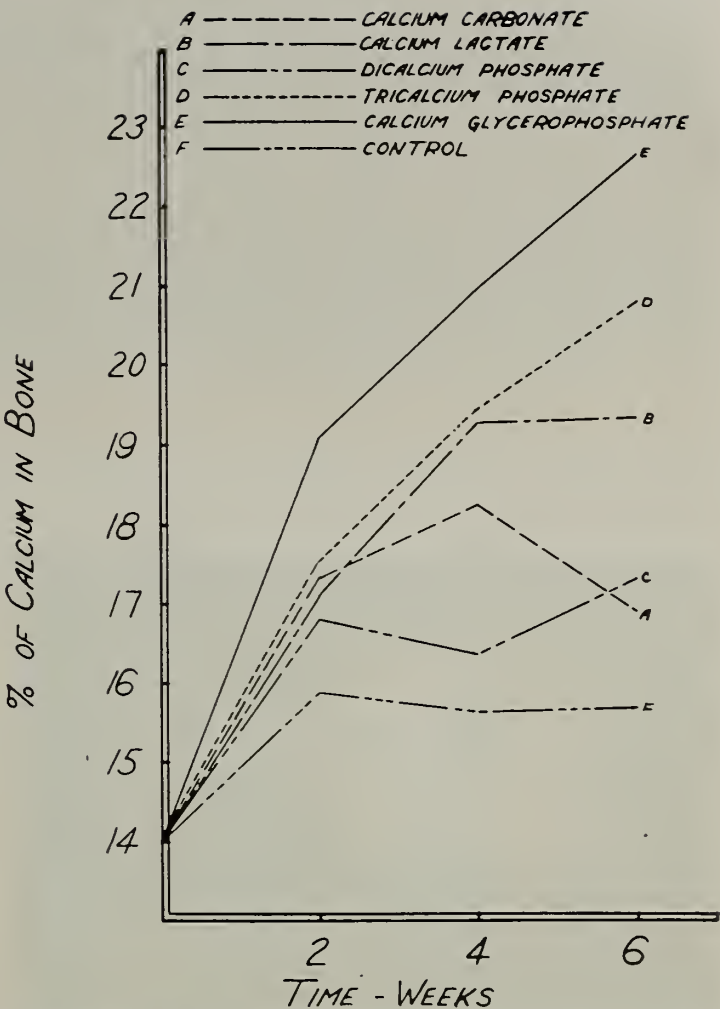


Fig. 2. Percentage of bone calcium obtained with various calcium supplements.

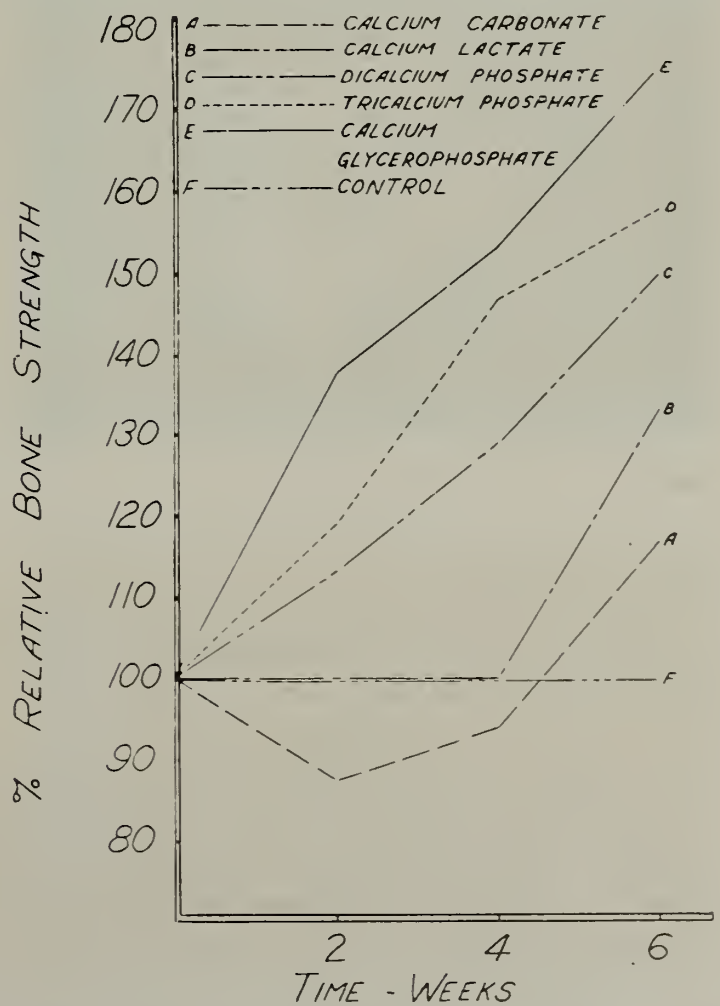


Fig. 3. Average increase of femur strength of mice on various calcium supplements using bone strength of control mice as 100 per cent.

*The authors are indebted to Mr. Kenneth A. Teague, now with the Department of Physiology, Ohio State University, for invaluable aid with the animal work.

ently showed a higher degree of bone calcification and bone strength than the control group (basic diet only) and the other groups maintained on the same basic diet, but supplemented with other types of calcium including calcium carbonate, calcium lactate, dicalcium phosphate and tricalcium phosphate (bone ash).

Results of the animal study seem to confirm expectations based on comparative solubility tests of the various calcium compounds which showed calcium glycerophosphate, despite its phosphate content, to be soluble throughout the pH range of the gastrointestinal tract, whereas other calcium compounds exhibited relative insolubility at pH 6 of the duodenum and pH 8 of



Fig. 4 (a). Basic diet plus 0.5 per cent (Ca.) as Calcium Glycerophosphate.

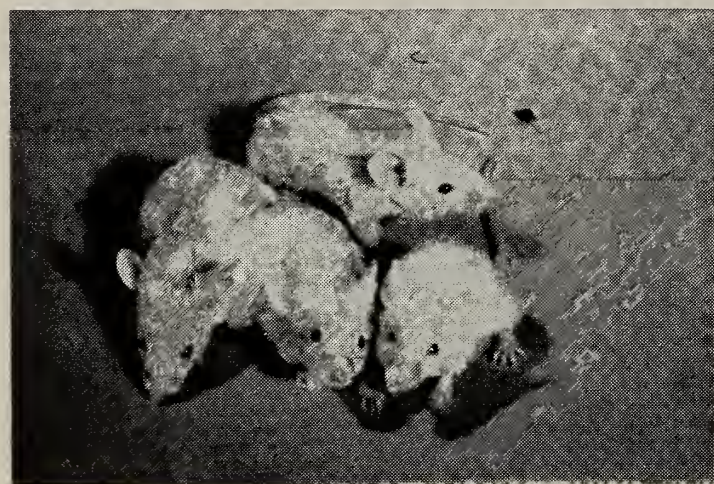


Fig. 4 (b). Basic diet plus 0.5 per cent (Ca.) as Calcium Carbonate.

the ileum in the presence of similar concentrations of phosphate.

Calcium tablets** containing 500 mg. calcium glycerophosphate as the supplement have proven to be clinically effective.^{28, 29, 30}

SUMMARY

Dicalcium phosphate appears to be an inadequate calcium supplement in view of its relative insolubility at pH levels prevalent in the duodenum. Dicalcium phosphate exhibited less than maximum efficiency in producing calcification of bone in laboratory animals.

The phosphorus-free calcium compounds also exhibited less than maximum efficiency in pro-

ducing calcification. The gross appearance of the animals was less than desirable particularly in the animals receiving the calcium carbonate supplement.

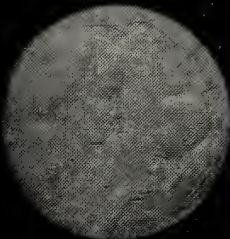
Phosphorus, when supplied in a form that is readily assimilable, appears to be highly desirable and essential to calcification. Supplementary phosphorus compounds, which tend to produce insolubility and to lessen absorbability of both calcium and phosphorus, however, have questionable value.

Calcium glycerophosphate, according to the results of this study, appeared to be superior to all of the commonly used calcium supplements, both as to solubility at duodenal pH and in producing calcification of bone under controlled laboratory conditions. With calcium glycerophosphate it is possible to avoid excessive losses of calcium by duodenal precipitation and at the same time, to provide available phosphorus to accommodate skeletal metabolism of the calcium supplied.

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**CAL-O-B—Trade name of Warren-Teed Products Company.



MATERNAL HEALTH IN OHIO

A CONTINUOUS state-wide Maternal Mortality Study is being conducted in Ohio by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health and assisted by official representatives of the various County Medical Societies of the state.

Since work of the committee is educational as well as statistical, summaries of some of the cases studied by the committee, based on anonymous data submitted, will be published in *The Ohio State Medical Journal* from time to time. Each presentation will be brief but informative. It will contain opinions of the committee, based on the data submitted for review. Two cases of maternal death due to infections are presented in this second report.

CASE NO. 78

This patient was an 18 year old negress, Para I, abortus I, who died three days postabortal. Her past history was not remarkable. It was believed she had had a stillborn fetus previously, but no details were available concerning the gestation or delivery. Nor was information available concerning the last pregnancy. On September 3rd she was seen for the first time complaining of vaginal bleeding for a month, abdominal pain, chills and a fever; she believed she was pregnant, but didn't know the stage of gestation, possibly 3 months or so.

After prompt admission to the hospital her temperature was found to be 105°, she was bleeding, and 12 hours later she passed completely a fetus of about 15 weeks' gestation, followed by the placenta; moderate bleeding preceded the placenta. Approximately an hour later, the patient's blood pressure suffered a marked drop. Intravenous fluids and supportive therapy were administered, and the next day the patient was considered "doing well" with blood pressure 114/70, pulse 120, respirations 24.

On September 6th, the patient received 1,000 cc. of whole blood. Intense therapy with antibiotics had been employed since her admission. On September 7th, late in the day the patient suddenly became worse, went into shock and delirium and finally died apparently of an overwhelming septicemia.

Blood Counts:

9/3 (Admission) RBC (red blood count) 4.17 mil.; WBC (white blood count) 7,600; PMN (polymorphonuclear neutrophil leukocytes) 71 per cent.

9/6 RBC 2.77 mil.; WBC 85,750; PMN 68 per cent, Juv. (juveniles) 23 per cent.

9/7 RBC 3.45 mil., WBC 73,000, PMN 60 per cent, Juv. 24 per cent.

Blood chemistry:

9/6 Creatinine 9.1, NPN (nonprotein nitrogen) 111.

9/7 Creatinine 9.7, NPN 123.

Cause of death: Septicemia and bronchopneumonia; abortion, infected. Autopsy permission

was obtained. *Pathological findings:* Same as stated in cause of death. However, microscopic study of tissue sections revealed additional findings: "Autopsy discloses sickled erythrocytes in all areas of the body, numerous small areas of infarction, severe suppurative endometritis and necrotic decidua. This appears to represent an unsuspected sickle-cell anemia in which the abortion played only a secondary role."

COMMENT

The Committee voted the death nonpreventable, with pregnancy and its complications indirectly responsible for the death. It was noted that following the large amount of blood transfused, the patient's condition became worse; in realization that the "sickled-cell" patient is "fragile," the Committee felt that multiple small transfusions might rather have been employed to a better advantage, although no member of the Committee had ever had a case similar to the one presented above.

CASE NO. 133

This patient was a 22 year old, white, Para I, who died 22 days postpartum. Her past history was not remarkable, and contained no note of any pelvic gynecological disorder; the last pregnancy was her first one. For that, she had registered with her physician in the fifth month, and visited him three times all told. Serologic test for syphilis, taken on the first visit, was reported negative. She was Rh positive; during the three visits, the prenatal course was described as being uneventful.

Spontaneously, at 32 weeks, labor began, and the patient was hospitalized. Two hours before delivery, the membranes ruptured spontaneously, and the patient was delivered spontaneously of a living 5 pound 9 ounce baby, episiotomy and repair, with nitrous oxide-oxygen anesthesia, administered by a physician. There was ample time for aseptic technique, according to the report; total length of labor was 15 hours. The

course was uneventful, and her postpartum course was the same.

She was discharged on her fifth day. Full details of this period of time are not available, but it was noted that about six days after she got home, she began to have pain in the lower abdomen; it is not known whether or not she consulted a physician but the pain continued for a week, whence she was readmitted to the hospital (17 days postpartum).

On admission the patient had chills, fever (102°), "sweats," pulse 110, distended abdomen with generalized abdominal tenderness. The lochia was profuse and foul. A consultant made the diagnosis of peritonitis from puerperal sepsis. Antibiotic therapy included: penicillin 100,000 units (intramuscularly) every 3 hours, sulfadiazine 1 Gm. every 4 hours, and next day streptomycin 0.2 Gm. every 3 hours (intramuscularly) and finally chloromycetin® was administered intravenously, twice daily. Forty hours after admission the therapy included Wangenstein's suction, hot turpentine stupes to the abdomen, small blood transfusions (250 cc.), demerol® 100 mg. every 4 hours for pain.

The following laboratory work was reported:

On admission:

WBC (white blood count) 8,700
Hematocrit 46 per cent
Neutrophils 86 per cent
Lymphocytes 14 per cent
Urine negative

48 hours after admission:

WBC 16,700
Hematocrit 49 per cent
Neutrophils 88 per cent

60 hours after admission:

Blood chemistry normal
Blood culture negative

84 hours after admission:

CO₂ combining power 30.9 mEq./L
Chlorides 101
Prothrombin 84 per cent
Potassium 4.7 mEq./L

Vaginal culture: hemolytic *Staphylococcus aureus*.

Smear: Rare gram-positive cocci.

The patient had increasing abdominal distension, and her temperature ranged from 102 (rectal) to 99 (R) with recurrent peaks of septic significance, the mean gradually rising to 104.4 (R) on the fifth hospital day. Likewise the pulse varied from 110 to 140 to 112, and the respiratory rate ranged from 22 to 40. Urinary output was normal. On the 22nd postpartum day the electrocardiogram revealed signs of a failing myocardium. The same day, the patient expired. Autopsy permission was obtained.

Pathological diagnosis: Acute salpingo-oophoritis, bilateral; superimposed old chronic salpingitis; generalized peritonitis; tubo-ovarian abscess with rupture; acute endometritis, myometritis, and cervicitis, with necrosis.

COMMENT

The Committee reviewed this case with much interest, and a great deal of discussion, and unanimously agreed that it was a maternal death.

It was agreed that the narrative report of the case was well prepared, and material was nicely submitted. However, members of the Committee were at a loss to know whether or not the physician had failed to ask about an old pelvic

infection in the patient's history, or whether the patient failed to reveal the information; likewise it was felt that a "key" portion of the chain of events was omitted in that there were no details concerning the conduct and course of the patient at home (sixth to tenth postpartum day), before the onset of her abdominal pain. Did she consult a physician? Finally, members of the Committee voted the death nonpreventable, at a very narrow margin nearly resulting in a tie-vote.

Although facts to substantiate the belief were not available, it was felt that the patient had acquired a virulent infection after she was discharged from the hospital. In view of the organism isolated from the vagina, larger doses of penicillin might have been employed, or one of the broad spectrum antibiotics could have been used.

PUERPERAL INFECTION UNCOMMON

The last case reported in the foregoing is of particular interest, since it represents the first case in this series to have become a maternal death, the result of puerperal infection ("puerperal fever" *per se*). True puerperal fever is becoming less frequent as a fatal complication of the puerperium due to its early recognition, and prompt treatment with potent and more specific antibiotics, especially those of the broad spectrum group. Even more promising is the early recognition of possibilities of the development of these infections, and the use of antibiotics as a prophylactic measure before the infection becomes rampant.

In the Franklin County Maternal Mortality Study (now operating for over eight consecutive years) there has not been one maternal death from "puerperal fever," in the 141 maternal cases studied. Various other studies throughout the United States have reported similar data.

Skin Reactions Caused or Aggravated by Sunlight

Before discussing eruptions due to sunlight, a brief review of the position of the sun in relation to the electromagnetic spectrum of radiant energy is apropos.

Radiation from the sun extends from the ultraviolet to the infrared, from 2,900A° to 30,000A°. Wave lengths shorter than 2,900A° are absorbed by the atmosphere and are not encountered on exposure. Between 2,800A° and 3,100A° the sun is exhibiting its most intense biological effects—its antirachitic and carcinogenic effects.

The erythema spectrum, or burning effect, is between 2,900A° and 3,100A°. This also is the wave length that causes pigmentation. Above 3,000A° existing pigmentation is intensified by sunlight. Window glass filters out the sun rays below 3,200A° but transmits higher wave lengths. —Otto C. Stegmaier, M. D., Moline: *Illinois M. J.*, 110:58, August, 1956.

Asphyxia in the Newborn—Pathologic Considerations

BENJAMIN H. LANDING, M.D.

DISCUSSION of the pathologic aspects of asphyxia of the newborn requires consideration of two overlapping groups of lesions—those causing asphyxia, and those resulting from it. However, because the emphasis of this symposium is on prevention and treatment of neonatal hypoxia, most of this presentation will be concerned with conditions interfering with the oxygen supply of the newborn infant. Here again, there are two interrelated but fundamentally independent aspects to consider: (a) conditions causing apnea, or failure to breathe, and (b) conditions causing respiratory distress, or difficulty in pulmonary aëration. This distinction is analyzed in detail in the valuable series of papers published recently from the laboratory of Dr. C. A. Smith.¹

APNEA

The four major causes of apnea or central respiratory failure, are narcosis, prenatal or intrapartum anoxia, intracranial hemorrhage or trauma, and central nervous system malformations. All of these can prevent the initial respiratory efforts of the newborn infant, by interference with or damage to the respiratory centers of the brain stem.

Central nervous system lesions of newborn infants resulting from hypoxia are poorly understood, in large part because of the difficulty of obtaining material from infants who have not been asphyxiated. Loss of functioning elements is the explanation most commonly given for neurologic sequelae of neonatal anoxia, but so many of these patients have apparently normal brains that some form of deviation of maturation patterns may well also be involved; this may, of course, be true of those patients with obvious ganglion cell loss, as well as of those without.

RESPIRATORY DISTRESS

Let us turn now to the larger group of conditions producing respiratory distress in newborn infants. The Marriott classification of unaërated lungs includes many of these disorders:

Apneumatosi—unaëration of lung tissue;

Anectasis—failure of lung to expand (“congenital atelectasis”);

Atelectasis—collapse of previously expanded lung;

Enchysis—filling of alveoli by fluid (edema, blood, exudate, gastric content, formula, amniotic fluid, etc.).

From the Departments of Pathology and Pediatrics of The Children's Hospital and Children's Hospital Research Foundation, Cincinnati, and the University of Cincinnati College of Medicine.

Presented as a portion of a panel discussion on Asphyxia in the Newborn, held at the Annual Meeting of the Ohio State Medical Association, Cleveland, April 10, 1956.

The Author

● Dr. Landing, Cincinnati, is directing pathologist, Children's Hospital, and Children's Hospital Research Foundation; assistant professor of pathology and pediatrics, University of Cincinnati College of Medicine.

More detailed analysis of the lungs of infants who die in the neonatal period is, however, necessary.

In a recently published study,² data were given as to the frequency of the following nine lung lesions in a series of consecutive autopsies on newborn infants: atelectasis, emphysema, interstitial emphysema, pneumonia (acute), pulmonary hemorrhage, pulmonary immaturity, hyaline membranes, aspiration of amniotic material including squamous cells, and pulmonary edema. Note that pulmonary immaturity here means absolute, not relative immaturity—namely, it refers to premature babies. We have never seen an infant with pulmonary immaturity relative to the state of maturity of the rest of the baby (as was implied by the concept, which we consider invalid, of congenital alveolar dysplasia).

PATHOLOGIC ANALYSIS

Analysis of the data concerning infants with major and minor degrees of these various lesions showed that the average newborn infant who dies has one major lung lesion and lesser degrees of three to four others (whence, in part, the difficulty of obtaining central nervous system material from infants who have not been hypoxic). This fact obviously complicates both diagnosis and treatment of neonatal respiratory distress.

In order to determine whether the situation is really this complex, and whether these nine lung lesions (and perhaps still others) all occur independently, the statistical analysis of this series of infants has recently been carried further.³ Each infant was assigned a punch card, with each lesion and its degree of severity indicated; each degree of each lesion was then sorted against every other. This maneuver gave data which could be handled by Chi-square analysis, with the following results:

STATISTICALLY SIGNIFICANT RELATIONS BETWEEN NEONATAL LUNG LESIONS

(Positive means that the two conditions tend to occur in the same infants, and negative means that they do not.)

Atelectasis—positive relation to pulmonary immaturity; emphysema; hyaline membranes.

Emphysema—positive relation to atelectasis;

interstitial emphysema; aspiration of amniotic material including squamous cells.

Interstitial emphysema—positive relation to emphysema; pulmonary immaturity; hyaline membranes.

Pulmonary hemorrhage—positive relation to pneumonia (acute).

Pneumonia (acute)—positive relation to pulmonary hemorrhage.

Negative relation to pulmonary immaturity; hyaline membranes.

Pulmonary edema—no significant relations.

Aspiration of amniotic material including squamous cells—positive relation to emphysema.

Negative relation to hyaline membranes; pulmonary immaturity.

Hyaline membranes—positive relation to pulmonary immaturity; interstitial emphysema; atelectasis.

Negative relation to aspiration of amniotic material with squamous cells; pneumonia (acute).

Pulmonary immaturity—positive relation to hyaline membranes; atelectasis; interstitial emphysema.

Negative relation to pneumonia (acute); aspiration of amniotic material with squamous cells.

What these results say is that infants dying as newborns fall into two general groups—one with a constellation of pulmonary immaturity, hyaline membranes, and interstitial emphysema, and another with aspiration of amniotic material including squamous cells, pneumonia, or pulmonary hemorrhage. Although these groups are by no means sharply defined or clearly distinguished, the first group reflects largely premature infants, and the second largely more mature babies.

Some of the negative relations observed in the statistical analysis are due to the fact that infants in the second group tend to live a day or two longer than infants in the first group; for example, the peak incidence of hyaline membranes occurs before that of acute pneumonia. Whether longer survival reflects simply greater size and strength, or has implications with regard to time of onset of these various conditions, cannot be stated.

At any rate, this general division into two groups reflects recent radiologic opinion, that diffuse fine pulmonary granularity is seen in infants with the "hyaline membrane syndrome," and coarser pulmonary reticulation with the "aspiration of amniotic sac content syndrome."⁴ The implications of this division, with regard to diagnosis and treatment of newborn infants with respiratory distress, must be left to other members of the panel.

With regard to causes of these pulmonary lesions, hyaline membranes and interstitial emphysema deserve special comment, although it can probably be said that the cause of neither condition is well understood. Among the theories which have been proposed to account for the genesis of neonatal pulmonary hyaline membranes are aspiration of amniotic sac contents, pulmonary edema, aspiration of gastric content,

oxygen intoxication, degeneration of the epithelium of the lower air-way, and congenital maldevelopment (alveolar dysplasia). At present, opinion seems to be favoring pulmonary edema,⁵ but the matter obviously requires much further study.

Interstitial emphysema is very probably badly underrated in current thinking about neonatal respiratory distress; its complications, mediastinal emphysema and pneumothorax, are quite generally respected by pediatricians dealing with these infants, but when the condition is restricted to the lungs it is not generally recognized. I hope that other members of the panel will present their opinions on the causes, diagnosis, and treatment of pulmonary interstitial emphysema in newborn infants. Our own series indicates that forceful resuscitative efforts are not usually responsible for the lesion, and that the infants are capable of producing the interstitial emphysema by their own respiratory efforts.

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Dermatomyositis an Unusual Disease Combining Skin and Muscle Changes

Dermatomyositis is an unusual disease, classified among the collagen diseases, that combines inflammatory and degenerative changes in the skin and muscle. It may be fatal.

The onset is usually fairly acute, with an erythema described as "heliotrope" in color, and edema which is often brawny, of the face and particularly of the eyelids, and muscular weakness, prostrating usually though by no means always. The edema and erythema may involve the extensor aspects of the extremities, and later progress to a mottled scaling with firmness in the texture of the skin and atrophy. There is an erythema of the hands occasionally, especially in children, which may be difficult to differentiate from that seen in lupus erythematosus of the disseminate type.

Weakness of the muscles may be so great that the patient may have difficulty in swallowing or talking, and there may even be regurgitation of fluids through the nose, with nasal speech. Muscular soreness may be present, though not always, and tenderness occurs sometimes even if the patient doesn't complain of aching.—Charles Sheard, Jr., M. D., Stamford, Conn., and Peter T. Knoepfner, M. D., Brooklyn: *Connecticut State M. J.*, 20:626, August, 1956.

Infant Weighing

CHARLES T. WEHBY, M. D.

THE importance of frequent and accurate weight determination in infants is universally recognized. This task demands simplicity, with safety and accuracy. The tool used today by nurseries, pediatricians, and general practitioners, is a special infant scale. The usual approach can be improved by a method which I have developed and used in my practice.

As stated previously, those who are dealing with infants generally use an infant scale, the infant's nude weight being, of course, the desired result. A blanket, covered by some disposable material, must be placed beneath the infant. The baby is then placed on the scale, and the weight determined.

If the baby is asleep, the reading usually can be made rather easily. As is usually the case, however, most infants will cry if not carried, and the attendant movement makes it difficult to get an accurate reading, until the baby becomes quiet. This is discouraging where frequent weighing is required. There is also the danger that injury may occur if care is not observed in handing the infant from mother, to attendant, to

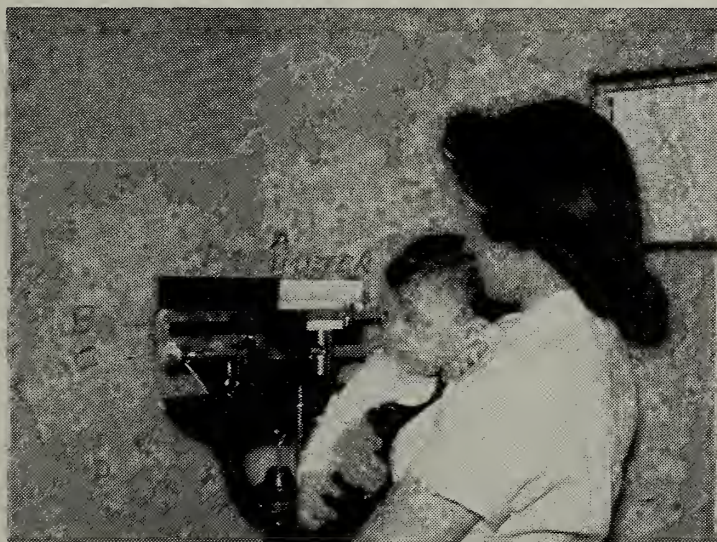


Fig. 1. The attendant obtains infant's weight accurately by use of Babimeter, as shown above.

- (A) Babimeter, a sliding scale, identical with the markings on the upper bar.
(B) The upper bar. (C) The lower bar.
(D) The scale frame.

scale, and back to the parent. Any method that can simplify and decrease danger to the infant is welcome. My approach, I believe, is the answer.

THE TECHNIQUE

An ordinary upright office scale is used. The operator first weighs herself and the disposable material accurately. For all practical purposes, this determination need only be taken one time daily if the same operator is used. As noted in figure 1, (A), a sliding scale, identical with the

The Author

- Dr. Wehby, Cincinnati, is a member of the staff of Catherine Booth Home and Hospital.

markings on the upper bar, (B), and rigidly attached to the scale frame, (D), has been designed by me. It embodies a handle lock mechanism for moving and locking the Babimeter scale. This unique mechanism is a part of U. S. patent No. 2,566,687, titled Stethoscope Heads, held by me.

The graduations are from zero to 25 pounds, which should accommodate infants who cannot stand alone and must be carried, or placed on a scale, to determine their weight. This sliding scale, called a Babimeter, is placed at the attendant's exact weight at its zero point. The operator then takes the nude infant from the mother and determines the increase in weight. When the scale is balanced, she merely has to read the Babimeter finding at that point and the reading will accurately determine the infant's weight.

If the operator's weight does not allow for sufficient length on the upper bar, (B), to determine the added weight of the infant, one merely adds 50 pounds to the lower bar, (C). The upper bar is placed back to zero and the Babimeter is placed at the same figure found at the 50 mark. The added weight then will accurately reflect the true weight. For example, if the operator weighs 148 pounds, the Babimeter, (A), will start at two pounds on the zero mark of the upper bar, (B), after 50 is added to the lower bar, (C), add 50 taken off of the upper bar, (B), to bring it to zero.

This method is simple, safe, economical, and accurate. It requires only one scale, together with the Babimeter. Danger to the infant is minimized, and weight determination is made easy.

Mediastinal Tumors in Children

The mediastinal silhouette seen in chest roentgenograms of children is subject to many individual anatomic variations, as well as upon the phase of inspiration, age, and physical habitus of the child and position at the time of filming. Recognition of these variations is necessary in order to avoid misdiagnosis. Mediastinal masses may be of congenital, inflammatory, or neoplastic origin.—Edward B. Singleton, M. D., and E. Wiley Biles, M. D., Houston: *Texas State J. M.*, 52:588, August, 1956.

Submitted March 7, 1956.

Children's Cardiac Diagnostic Centers

ROBERT A. LYON, M.D.

CHILDREN'S diagnostic clinics are designed to provide consultation service for physicians who live in areas where the highly specialized tests and facilities for cardiac surgery are not available. No general practitioner or pediatrician sees a large number of children with rheumatic or congenital heart disease, and he welcomes the opportunity to discuss the more difficult patients. The consultant also has a chance to understand better the problems of incipient heart disease and the long term care of the child with heart disease in rural communities.

Consultation clinics have now been established in four different areas in southwestern Ohio. A few years ago we reviewed our experience with two of these clinics and described in detail their organization and the procedures which we followed then and which remain unchanged today.¹ From this study we concluded that very few instances of heart disease were uncovered in the clinics which had not been known previously by the family and diagnosed with considerable accuracy by the doctor. Inconsequential symptoms and murmurs however had frequently caused undue alarm in patients and their parents.

An important contribution of the consultant was his diagnosis of the innocuous nature of functional murmurs which occurred as the sole disturbance in 50 per cent of the children attending the clinics. The consultant was also useful in supporting the family doctor's plan of treatment, and whenever serious heart disease of doubtful etiology was encountered, he was particularly able to supply easy means for channeling the patients to hospitals and convalescent homes for diagnosis and treatment.

EXPANSION OF SERVICE

In recent years two additional clinics have been added, and a total number of seven visits are made annually to the four areas. As the years go by, it has been interesting to follow the postoperative course of patients who underwent surgical treatment some time previously. Particularly gratifying has been improvement in the number of children who had originally resisted treatment or had been indifferent to regular medical care. One child with tetralogy of Fallot had once been brought as far as the hospital door before the parents had turned back in fear vowing never to let their child leave home for medical care. Not for two more years would they even visit the clinic, but finally within another year, when the child reached the age of 14 years, he

The Author

● Dr. Lyon, Cincinnati, is medical director of The Children's Heart Association of Cincinnati; associate professor of pediatrics, The University of Cincinnati College of Medicine.

became so incapacitated that the family consented to operation. Following the procedure he was able to go to school for the first time in his life and lead a life of fairly normal activity.

Another patient, a girl with advanced rheumatic heart disease, was thoroughly discouraged with her lot and her parents failed to keep her appointments with the doctor. She was finally persuaded to follow carefully her physician's instructions in regard to taking penicillin daily for the prevention of recurrences of infection. In addition, glasses were secured to help her defective vision, and dental care given for her severely decayed teeth. She is now an attractive adolescent girl attending school regularly, greatly improved in body and spirit.

There was nothing unusual in the treatment of these children and every physician in the community had accomplished similar results in other patients. In specific instances, however, the weight of authority carried by the out-of-town consultants strengthened the program of treatment needed by these certain children.

An impressive change occurring in the past eight years of these clinics has been the increasing awareness of the physicians of the need for prophylactic treatment of rheumatic patients. The number of new rheumatic patients and of severely affected ones has greatly declined in these rural areas, keeping pace with the trends elsewhere in the nation.

RESULTS

The extent of the work over the past eight years has been expressed in the data of attendance and diagnoses listed in table 1 and table 2.

DISCUSSION

The conduct of these clinics has been an example of excellent cooperation between local medical societies, public and private health agencies, and a University department. As mentioned in a previous report¹ the local medical society was the key organization. If the society decided it wanted a clinic, after thorough discussion of the project, it initiated arrangements and either operated the diagnostic clinic with assistance from the public health nurses, or it turned over all of

¹Read at the Annual Meeting of the Ohio State Heart Association in Cleveland, April 9, 1956.

TABLE 1—ATTENDANCE OF 592 CHILDREN WHO MADE 877 VISITS AT CHILDREN'S CARDIAC DIAGNOSTIC CENTERS, 1948-1955

	1948	1949	1950	1951	1952	1953	1954	1955	Total
Xenia	109	46	59	51	61	58	84	88	556
Washington C. H.	24	28	21	20	20	22	18	16	169
Hillsboro				27	27	35	23	17	129
West Union								23	23
Total	133	74	80	98	108	115	125	144	877

TABLE 2—DIAGNOSES OF HEART DISEASE IN 592 CHILDREN WHO ATTENDED CHILDREN'S CARDIAC DIAGNOSTIC CENTERS FROM 1948 THROUGH 1955

	Hillsboro	West Union	Washington C. H.	Xenia	Total
Rheumatic	27	11	21	76 (23%)	135
Congenital	19	3	25	88	135
Functional	29	3	32	131	195
Normal hearts	9	4	23	60	96
Other Conditions	1	2	5	23	31
Total	85	23	106	378	592

the details of planning and staffing of the clinic to the public health department. Both systems have worked well.

The visiting diagnostic team consisted of two or three physicians, a nurse, a technician to take electrocardiograms and a secretary to type reports to the individual physicians who had referred the patient. Copies of these reports provided permanent records of the physical findings, diagnosis and suggestions for treatment.

Physicians of the community frequently attended the clinics to discuss their own patients or to observe interesting cardiac conditions. Personal conferences between consultant and family doctor regarding particular children were often held at the time of the examination or after the clinic was over. In all instances formal reports were also submitted by the consultant to the referring physician.

In three counties the clinics have been held in hospitals and the fourth in the offices of the county Health Department. In all sites, fluoroscopes were available. The team brought its own electrocardiograph. At first, facilities for blood tests of sedimentation rate, hemoglobin and white cell values were provided, but these tests were employed infrequently because so few children were in active stages of rheumatic fever. More and more often the physicians in the community supplied current laboratory tests of their patients, when the indications suggested the need.

Supporting the entire project has been the Division of Social Administration of the Department of Public Welfare of the State of Ohio. Its doctors and nurses have supervised the organization of the clinics, have defrayed the expenses of the visiting diagnostic team, and it has also been willing at all times to assume its share of the costs which confront patients who need special tests or surgical treatment.

A great deal of stress has been placed upon the educational possibilities of such a program.

In the realm of professional education, the program has been successful. The cardiologists gained a great deal of knowledge regarding the incidence and treatment of heart disease in rural communities and the conditions under which therapy must be carried out.

For the laity, not much has been added in the field of education by the consulting staff except the personal conferences with parents at the clinic. Although all forms of health education would seem to be good, there are some dangers associated with the subject of heart disease. It causes alarm at all ages of life, and many parents visiting the clinics were unduly concerned by the symptoms of their children. Since the instances of parental indifference or neglect were rare, community educational programs should avoid frightening parents and children and should emphasize the positive side of hope and favorable outcome of heart disease if treatment is started early in the course of the disease.

SUMMARY

1. Seven children's cardiac diagnostic clinics are held annually in four centers in southwestern Ohio under the auspices of the local Medical Societies, the Division of Social Administration of The Ohio Department of Public Welfare and the Children's Heart Association of Cincinnati.
2. During the past eight years 592 children have made 877 visits to these clinics.
3. The consulting cardiologists have learned a great deal about the problems of treatment confronting the physician in a rural environment, and in turn have been able to offer him easy access to facilities for diagnosis and treatment of difficult cardiac conditions.
4. The clinics offer opportunities for professional and lay education in matters of heart disease of children.

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Observations on Pantho-F® Ointment*

ASHTON L. WELSH, M. D., and MITCHELL EDE, M. D.

WE HAVE reported our observations of response to hydrocortisone ointments in the treatment of patients with selected dermatoses.¹ We have also reported our experience with a water-miscible cream containing 2 per cent pantothenylol (trade-name panthoderm®) as a therapeutic adjuvant and as a potentiating dermatological vehicle.² Since these reports, we have continued our studies of each of these agents to include observations on 3,769 patients using hydrocortisone and 390 patients using pantothenylol. These further studies confirmed the observations originally reported on the use of each agent. It was logical for us, therefore, to undertake study of the therapeutic value of a cream combining both 2 per cent pantothenylol and 1 per cent hydrocortisone free alcohol (trade-name pantho-F® ointment).

Hydrocortisone has been repeatedly reported to exert a marked anti-inflammatory action at cellular levels. The exact mechanism of this action is unexplained.¹ Pruritus disappears, oozing and edema are controlled, erythema fades, crusting and scaling lessen, and the skin begins a return to normal. Clinical evidence of percutaneous absorption, such as edema, weight gain, et cetera, has not been reported, or observed in our own series of 3,769 patients. Laboratory evidence exists of absorption percutaneously of small amounts which are insignificant since the quantity is insufficient to produce untoward systemic effects.³⁻⁵

Topical application of pantothenylol, the active alcohol analog of pantothenic acid, has been observed to favor regeneration and functional recovery of damaged epithelium in dermatoses of various causes involving both skin and mucous membranes.⁶ The authors reported evidence of recovery of damaged epithelium, particularly on the oral mucosa; stimulation of epithelization, most marked in hypostatic dermatitis with ulceration; resolution of maceration with healing of fissures and excoriations in pruritus vulvae, pruritus ani, senile vulvitis and in perlèche of the malocclusion type.² We observed no evidence of sensitization and none has been observed by others.^{2, 6}

Evidence of antibacterial action of pantothenylol has been suggested by several observers.⁶ We performed the following experiment in an effort to demonstrate some bacteriostatic prop-

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● Dr. Ede, Cincinnati, is instructor, Department of Dermatology, University of Cincinnati College of Medicine.

erties of pantothenylol 2 per cent in a water-miscible cream (panthoderm®) for both a representative bacillary and a coccal type of bacterium.

METHOD

Two sets of four agar plates each were prepared. One set contained agar lightly inoculated with *Micrococcus aureus* strain S-209, the other contained agar lightly inoculated with *Escherichia coli* strain 198. After the agar had hardened a sterile 10 ml. cork borer was used to cut 4 cups through the agar layer in each plate. The base of each of these cups was sealed with a few drops of melted sterile agar. The test ointment was placed in a sterile 20 ml. syringe and expelled directly into 3 cups on each plate filling them to the upper edge. The fourth cup served as the positive control and contained sterile water instead of the ointment. After incubation under absorbent tops of 37°C, the periphery of each cup was examined for growth. Two plates were prepared as above except uninoculated agar was used. These served as sterility controls.

RESULTS

No zone of inhibition was present around any cup. There was a narrow zone of growth stimulation around ointment cups on plates inoculated with *E. coli*; this was not noted on plates inoculated with *M. aureus*. There was no growth on the sterility control plates.

CONCLUSION

Panthoderm® ointment has no bacteriostatic action against *M. aureus* or *E. coli*.

It seemed clearly advantageous to combine pantothenylol and hydrocortisone in the treatment of certain selected dermatoses, since pantothenylol may aid in the functional recovery of damaged epithelium, stimulation of epithelization, resolution of maceration and the healing of fissures and excoriations while hydrocortisone

*U. S. Vitamin Corporation supplied the pantho-F® ointment used in this study.

Submitted March 17, 1956.

TABLE 1—RESULTS OBTAINED IN THE TREATMENT OF SELECTED DERMATOSES

Dermatoses	No. Cases	Results with Pantho-F				Number Previously Used Hydrocort. Alone	Comparison with Hydrocortisone		
		Good	Fair	Poor	Reactions		Better	Equal	Poorer
Actino-dermatitis	3	1	1	1	---	3	3	---	---
Post-irradiation dermatitis	6	6	---	---	---	6	4	2	---
Stasis dermatitis	12	11	1	---	---	11	6	5	---
Atopic dermatitis	17	14	3	---	---	15	2	10	3
Contact dermatitis	21	14	5	2	---	18	2	15	1
Chronic Infectious Eczematoid Dermatitis	51	26	20	5	---	47	3	42	2
Neurodermatitis	5	2	2	1	---	5	1	4	---
Cheilitis	11	8	2	1	---	10	6	4	---
Pruritus ani and vulvae	11	10	1	---	---	11	6	5	---
Perleche	12	10	1	1	---	11	7	4	---
Gingivitis	1	---	---	1	---	---	---	---	---
Seborrheic dermatitis	6	3	2	1	---	5	---	4	1
Psoriasis with eczematization	2	---	1	1	---	2	---	2	---
Leukoplakia	5	2	2	1	---	5	2	3	---
Lupus Erythematosus (Oral)	5	5	---	---	---	5	4	1	---
Balanitis xerotica obliterans	1	1	---	---	---	1	1	---	---
Insect bites with eczematization and excoriation	1	---	1	---	---	1	---	1	---
Total	170	113	42	15	---	156	47	102	7

controls the underlying disorder through its anti-inflammatory action.

The formula of pantho-F® ointment is as follows:

cetyl alcohol	15%
spermacetti	5%
glycerine	5%
pantothenylol	2%
hydrocortisone (as free alcohol)	1%
oil in water emulsifying agent	1%
stabilizing agent	.08%

The resulting cream is an oil in water type. Pantho-F® ointment was prescribed for application three or four times daily, by gently smoothing onto and into the skin or mucous membrane of the affected areas. All patients were observed at weekly intervals. The accompanying table 1 summarizes results obtained in selected dermatoses.

COMMENT AND SUMMARY

A total of 170 patients were treated topically with pantho-F®. Of these patients, 113 (66.5 per cent) had good response, 42 (24.7 per cent) had fair response and 15 (8.8 per cent) had poor response. There was no evidence of sensitization. In this group were included 156 patients who had previously used topical hydrocortisone alone. The response to pantho-F® and to hydrocortisone alone was equal in 102 (65.5 per cent) of these patients. In 47 (30.1 per cent) patients pantho-F® was superior and in 7 (4.4 per cent) it was inferior in effect to hydrocortisone alone.

Pantho-F® ointment proved more effective particularly in the following dermatoses: actinic dermatitis and post-irradiation dermatitis, stasis dermatitis (with or without ulceration), cheilitis (particularly with fissuring), pruritus vulvae and ani (particularly with maceration and fissuring), perleche of the malocclusion type (particularly

with extensive maceration and fissuring) and the oral ulcerative lesions of lupus erythematosus. Pantho-F® therefore appears to be the agent of choice over ointments containing hydrocortisone alone in the treatment of the foregoing group of dermatoses.

We were unable to demonstrate any bacteriostatic action of pantothenylol (as panthoderm® ointment) by the method we employed.

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Newer Developments in Etiology and Treatment of Atherosclerosis

Atherosclerosis is a disease associated with a disturbed metabolism of lipid and/or cholesterol. There is evidence that dietary factors play an important role in its development. Many other factors also play a role.

Present evidence is felt to justify the inclusion of a low fat diet in the therapeutic program of the patient with any of the atherosclerotic diseases. A prophylactic, less drastic reduction in the level of fat intake for the population as a whole is felt to be worthy of serious consideration.—E. Harvey Estes, Jr., M. D., Durham: *North Carolina M. J.*, 17:348, August, 1956.

Central Nervous System Influence in the Genesis Of Atrial Fibrillation

JACK MARKS, M. D.

THE validity of the circus movement as a mechanism for atrial fibrillation has been both affirmed and refuted on the basis of recent studies.^{1, 2, 3} While the intrinsic modus operandi of atrial fibrillation has been studied extensively, information has been scanty regarding the influence of higher nervous centers in the production of this disorder. Those brain stem centers that influence heart rate in animals via the autonomic nervous system have long been known. That the counterpart of such centers in the human being are occasionally subject to volitional control seems established in the ability of Hindu fakirs to alter heart rate at will.

Reference to arrhythmicity occurring as a feature of central nervous system influence is difficult to obtain from the literature. The standard texts of cardiology^{4, 5} state that paroxysmal atrial fibrillation is frequently observed in persons without heart disease, frequently the young, apprehensive, so-called neurasthenic male. Thus the central nervous system does apparently influence the cardiac rhythm. Manifestation of such influence has been observed in two patients with spontaneous subarachnoid hemorrhages who demonstrated atrial fibrillation when seen initially. Neither was known to have heart disease.

CASE REPORTS

Case 1. Mr. _____, a 22 year old white salesman, was admitted to the Youngstown Hospital* on January 24, 1955, with severe frontal headache, nausea and vomiting. The patient was said to have been well until late afternoon of the day of admission when, on returning home from work, he lay down because of a sense of general malaise. He experienced a sudden severe frontal headache, became nauseated and began to vomit. When seen in the emergency ward shortly after, the patient was found clutching his head in obvious pain and vomiting.

The past history revealed that for approximately one year he had experienced what were interpreted as premature systoles. There was no history of rheumatic fever or any other previous symptoms of cardiovascular disease.

On physical examination the patient had a blood pressure of 110/70 and had atrial fibrillation. The heart was thought to be slightly enlarged with the point of maximal impulse in the fifth intercostal space, 2 centimeters lateral to the mid-clavicular line. The patient had marked nuchal rigidity. The remainder of the physical examination was negative with the exception of the meningeal signs. An electrocardiogram was taken which showed atrial fibrillation at approximate rate 120. Ectopic QRS complexes of probable ventricular origin were noted.

Submitted February 17, 1956.

*Youngstown Hospital Association, Youngstown, Ohio.

The Author

● Dr. Marks, Columbus, is senior assistant resident, Department of Medicine, The Ohio State University Health Center.

A lumbar puncture shortly after admission revealed grossly bloody spinal fluid. Opening pressure was 160 mm. water; closing pressure was 140 mm. water. The complete blood count on admission revealed a normal red blood cell count with a white blood cell count of 25,050 with 85 per cent neutrophils. Blood cultures taken on admission were negative. Shortly after admission the patient's cardiac rhythm reverted to sinus rhythm with a bradycardia of 60. This slow rate persisted throughout the patient's hospitalization. The electrocardiogram showed regular sinus rhythm of rate 60. P-R interval was .18 sec. Duration of QRS was .08 sec. A well defined U wave was seen in Leads V 2, V 3 and V 4.

A chest film taken the third hospital day showed a normal heart silhouette and normal lung fields. The patient was afebrile and had gradual clearing of his headache. Subsequent lumbar punctures on the fourth and fourteenth hospital days revealed 44,040 red blood cells and 32 red blood cells respectively. Angiographic and pneumoencephalographic studies were deferred because of the patient's persistent bradycardia. The patient was discharged on the fourteenth hospital day.

Case 2. Mr. _____, a 39 year old, slightly obese white male, was admitted to the Youngstown Hospital on January 10, 1955. Just prior to admission the patient had been in the bathroom and was heard to cry out by his wife who found him lying on the floor disoriented and complaining of severe frontal headache. The patient lapsed into unconsciousness a short while later and was brought to the emergency ward.

He was described as being semi-comatose, having sonorous respirations and left sided weakness. The blood pressure was 170/94. The pupils were described as reacting sluggishly to light and the right pupil was enlarged. Nuchal rigidity was pronounced. The heart was irregular in rhythm and a Grade I systolic murmur was heard over the entire precordium. The patient's deep tendon reflexes were symmetrical and not exaggerated. Babinski reflexes were described as equivocal bilaterally. An electrocardiogram was taken on admission which showed atrial fibrillation of approximate rate 80. Ectopic QRS complexes were noted, probably nodal in origin.

When seen by a neurological consultant the following morning blood pressure was 212/112. Fundusoscopic examination at that time showed multiple flame hemorrhages scattered in the right retina. An electrocardiogram taken on the second hospital day showed a rate of 60, non-phasic sinus arrhythmia with partial A-V dissoci-

ation and multifocal nodal and atrial premature contractions. Diphasic T waves were noted in Leads V 5 and V 6.

A lumbar puncture on the seventh hospital day showed an opening pressure of 535 mm. water and a closing pressure of 240 mm. water. The fluid was grossly bloody in character. On the eighth day, papilledema of both fundi was noted. A repeat lumbar puncture on the eleventh hospital day showed an opening pressure of 380 mm. water and a closing pressure of 120 mm. water after 10 ml. of pink cerebrospinal fluid were withdrawn.

The patient's condition remained poor and on the fifteenth day a ventricular catheterization was performed. The patient seemed to improve briefly, but on the eighteenth hospital day he developed generalized convulsions and began to drain blood through the ventricular catheter. He expired a short time later.

At autopsy a ruptured cerebral aneurysm at the junction of the basilar artery and the posterior communicating arteries in the circle of Willis was found. The heart weighed 350 grams and the four valves showed no abnormalities. The right ventricle measured 4 mm. in thickness, and the left, 16 mm. The coronary vessels contained some atherosclerotic deposits but no obstruction could be demonstrated through their extent. The aorta was of normal diameter and showed scattered, slightly elevated atheromatous plaques.

DISCUSSION

It would appear from the foregoing that the central nervous system, probably the medullary and pontine cardioregulatory centers might have been instrumental in the development of atrial fibrillation in these two patients. The subsequent bradycardia would seem to indicate that vagotonia was a factor in its development. Insofar as the exact mechanism of the atrial arrhythmias still remains in contention it would appear that the role of the central nervous system is a factor that warrants further consideration in the elucidation of their genesis.

Acknowledgment: Dr. David Belinky and Dr. Samuel Epstein, Youngstown, Ohio, kindly allowed their respective case histories to be used in this report.

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Surgical Therapy for Diverticulitis

For the most part, diverticulitis can be managed by rest, diet, antispasmodics and antibiotics but at present definitive surgery can be performed safely in those chronic, recurring, and thus chronically ill cases, as well as in those emergent conditions such as perforation, fistula and obstruction.—Marion N. Malinowski, M. D., et al., Charleston, W. Va.: West Virginia M. J., 52:289, September, 1956.

KEEPING UP WITH MEDICINE

• THE MAJORITY of people add salt to their food as a condiment in amounts which outweigh that naturally in foods. This is purely a matter of taste and not necessity.

* * *

• ALCOHOL increases the flow of gastric juices, has a carminative effect on the stomach, and when mixed with other foods has no unfavorable effect upon digestion.

* * *

• SENILE EMPHYSEMA is for the most part of little serious significance.

* * *

• SPECIFIC passive prophylaxis for infectious hepatitis is afforded by intramuscular injection of 0.01 ml. concentrated human gamma globulin per pound of body weight.

* * *

• EXPERIMENTALLY, high cholesterol levels can be lowered more or less effectively by a low fat, low cholesterol diet containing not more than 60 grams of fat per day or by the addition of plant sterols to a normal diet.

* * *

• FOOD HABITS are conditioned reflexes.

* * *

• DIAMOX® appears to have a special place in treatment of chronic cor pulmonale. It serves to maintain blood bicarbonate at lower levels and at the same time it appears to lessen the tendency to edema formation.

* * *

• OBESITY increases the liability to degenerative diseases like hypertension, pulmonary emphysema, diabetes mellitus, atherosclerosis, and perhaps other diseases.

* * *

• THE HISTOPATHOLOGY of the nephrotic syndrome is quite different from that of acute, diffuse glomerulonephritis.

* * *

• CONSTIPATION is usually due to one of three main causes, two of which are helped by diet; i.e. dyschezia and spasticity of colon.

* * *

• THE MOST TYPICAL and characteristic manifestation of the nephrotic syndrome is heavy proteinuria. The sedimentation rate is very rapid. The plasma is creamy. Loss of concentration is an early sign.

* * *

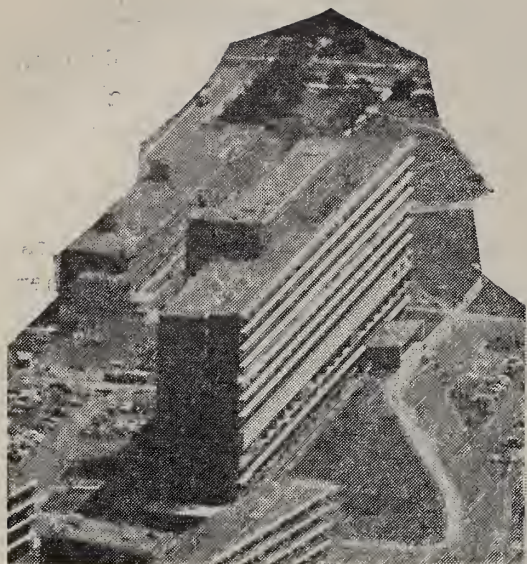
• WE KNOW all too little about flavor of foods.

* * *

• PRESSURE cooking retains more of the ascorbic acid content than cooking in the usual way.

* * *

• THE PROMPT USE of the newer antibiotic agents in acute respiratory infections prevents further degeneration which accompanies the flare-up of a chronic infection in senile emphysema.—J. F.



A Case Record

From The University Hospital,
Columbus, Ohio

Edited Under the Auspices of the Ohio Society of Pathologists

Philip Wasserman, M. D., President

Presented by Robert L. Wall, M. D., and Emmerich von Haam, M. D.

Edited by Dr. von Haam

PRESENTATION OF CASE

SIX WEEKS prior to admission to University Hospital this 43 year old white male suffered a sore throat which subsided following treatment with penicillin. One week later, however, his ankles became very painful, hot, red and swollen. The patient was generally afebrile at that time and only on several occasions did his temperature rise, once to 99°F, and once to 100°F. Blood cultures taken in the outpatient clinic were reported positive for staphylococcus and streptococcus. He was treated with combiotic® and cortisone and the joint symptoms subsided.

Four to five weeks later the joint lesions recurred and he was admitted to University Hospital. At this time the patient exhibited generalized fatigue and malaise and the skin of both legs showed petechiae. He had lost weight but the exact amount was not known.

PHYSICAL EXAMINATION

The patient appeared well developed but acutely ill. The blood pressure in the right arm was 160/100, in the left arm 170/100; the temperature was 101°F., the pulse 80 and the respirations 22 per minute. The pupils were round, equal and reacted to light and accommodation. The visual fields were normal; the fundi showed no evidence of hemorrhages or exudates; however, there was slight narrowing of the vessels. The sclerae were not icteric. There were crust-covered hemorrhagic lesions over the lower lip. There were petechiae over the buccal mucosa and pharynx. Small nontender lymph nodes were palpable in the neck bilaterally. There was no venous distention.

Breath sounds were decreased at both bases and diffuse rales were audible at both bases and

over the anterior chest. A systolic murmur was heard over the pulmonic and mitral areas. The second aortic sound was louder than the second pulmonary sound; the latter was split, with no accentuation of the first mitral sound.

The abdomen was distended and a slight fluid wave could be elicited. The liver was palpable 4 finger-breadths below the right costal margin. There was minimal costovertebral angle tenderness on the right. There were petechiae and 4 plus pitting edema of both ankles and 2 plus presacral edema. The prostate was slightly enlarged but was neither hard nor nodular.

LABORATORY DATA

The admission white blood count was 8,400 with 8 per cent nonsegmented forms, 84 per cent segmented, 5 per cent lymphocytes and 3 per cent monocytes. Later his white cell count rose to 26,000 with a high percentage of polymorphonuclear leukocytes but no eosinophils. The red blood cells numbered 5.3 million, the hemoglobin was 13.9 Gm. The bleeding time was 3 min., 45 sec., the coagulation time 12 min., 45 sec. The platelet count was 140,000. The corrected sedimentation rate was 34 and the hematocrit 39 per cent.

The urinalysis revealed a specific gravity of 1.016, protein 640 mg., no sugar or acetone; a few white blood cells and many red blood cells per high power field were found on microscopic examination. The blood urea nitrogen on admission was 36 mg.; it showed a gradual rise to 123 mg., followed by a decline to 90 mg. The prothrombin time was 65 per cent of normal; thymol turbidity was 10. The van den Bergh test was .1 mg. direct and .4 mg. indirect. The plasma protein amounted to 5.7 Gm. with 3.3 Gm. albumin and 2.3 Gm. globulin.

The serum sodium was 148 mEq., the potas-

Submitted July 24, 1956.

sium 3.5 mEq., and the chlorides 96 mEq. During his hospital stay his serum potassium ranged between 1.5 and 4.8 mEq. His serum calcium was 8.3 mg. and the inorganic phosphorus was 5.1 mg. The CO₂ combining power was 67 vol. His serum cholesterol was 183 mg. with 57 per cent esters. The serologic test for syphilis was negative. Lupus erythematosus preparations repeated on two occasions were negative. The antistreptolysin titer was 250. Urine culture revealed a few *E. coli*. Nose and throat cultures grew hemolytic *S. aureus*, diphtheroids and neisseria. Blood cultures were negative.

ROENTGENOGRAPHIC EXAMINATION

A chest film showed cloudiness of the mid-zone of his left side and similar changes in the upper mid and lower zones of the right side. This was interpreted as acute pulmonary edema. There was also a calcified focal lesion in the right middle lobe. Repeat chest films showed a diffuse parenchymal infiltration of the left lung field obscuring the left border of the heart. The right lung showed a similar but less extensive confluent patchy infiltration. The size of the heart could not be evaluated because the films were taken with a portable machine. There was no definite evidence of pleural effusion. The latter lung findings were compatible with a bilateral pneumonitis. X-ray examination of the abdomen was essentially normal.

HOSPITAL COURSE

The patient remained febrile during the first five days of his hospitalization. During this time he remained very anorexic, lethargic and vomited frequently. Nine blood cultures taken were all negative. He was placed on combiotic® and diamox®, was digitalized and given intravenous fluids rich in potassium in order to increase the potassium of his blood. On this regime the blood urea nitrogen continued to rise slowly and the potassium level became difficult to control. He was placed on thorazine®, 600,000 units of penicillin three times daily and neo-syneprine® by nose drops.

In the third week of his hospital stay the patient began to take some food by mouth and his nausea and vomiting ceased. His blood urea nitrogen dropped to 99 mg. and remained at about that level. During the rest of his hospital course the patient remained afebrile. His blood pressure remained high throughout his hospital stay. He was placed on meticcorten®, 5 mg. daily, but in spite of all therapy the patient continued a downhill course and expired quietly on his twenty-fifth hospital day.

CLINICAL DISCUSSION

DR. ROBERT WALL: We have before us the case of a 43 year old white male admitted for fever, painful and swollen joints and red spots on both legs. The duration of his illness, which

proved fatal, was not very long and developed one week after he had been treated by his physician with penicillin for a sore throat. The patient was practically afebrile and his symptoms would make one think of some sensitivity disease such as nephritis or rheumatic fever, although the time interval between the actual acute incident and the sequela is rather short.

The one positive blood culture obtained in the outpatient department contained a mixed flora and therefore could well have been a result of contamination. I believe from the chart that other blood cultures were taken and it was only this one that showed any growth.

His joint manifestations disappeared after treatment with combiotic® and cortisone but recurred and were associated with generalized malaise, fatigue and some weight loss. In a patient who has had hot, red, swollen joints following a sore throat and develops petechiae, we should surely think about glomerulonephritis, possibly rheumatic fever, and not knowing any other history, possibly subacute bacterial endocarditis, especially with his mild febrile episode following an acute upper respiratory infection.

BLOOD PRESSURE

His blood pressures were elevated and although we do not know whether he was hypertensive prior to his illness we do know that he was so in the hospital. We don't know either whether his distended abdomen was due to ascites or distended bowel. The eye examination showed the extremely important fact that the eyegrounds except for minimal arterial narrowing were normal. The heart murmur heard over the pulmonic and mitral areas was systolic and the accentuated second aortic sound might be explained by his hypertension. He apparently had an enlarged liver and some ascites. There were petechiae over both ankles and 4 plus pitting edema of the ankles.

Thus we are dealing with a patient who had this brief acute episode of illness with a short latency period and recurrence of his symptoms and who now presents himself with petechiae, some rales in his chest, hypertension, enlarged liver, ascites, and a lot of dependent and pre-sacral edema from being in bed, I imagine. This is surely not the typical picture of someone with rheumatic fever, although it may be possible. It is rather the clinical picture that we could expect in somebody who had a diffuse generalized disease. It is compatible, I am sure, with the picture of acute glomerulonephritis, although his lung findings were not entirely typical.

The admission white blood cell count was 8,400, which is a little low for somebody who is febrile and apparently severely ill with a generalized disease and which suggests to us some leukopenic disease such as lupus erythematosus or typhoid fever. Later, however, he developed leukocytosis.

The platelet count was normal and that eliminates thrombocytopenia as the possible origin of his petechiae.

The urinalysis showed a specific gravity of 1.016 and 640 mg. of protein, which means that even after we correct the specific gravity for the amount of protein the urine is still concentrated above the glomerular filtrate—an unusual finding in somebody with severe chronic glomerulonephritis. And the observation that it was loaded with red blood cells without too many white cells present in the sediment suggests the possibility of renal hemorrhage rather than hemorrhagic pyelonephritis.

His antistreptolysin titer was elevated, which may be explained by his streptococcus sore throat six weeks before. If he had a really severe streptococcus sore throat, I would like to see it much higher. His total serum protein was slightly below normal, and so was the albumin. It is also possible that some of it may have been alpha globulin, which is characteristically elevated in febrile conditions and renal diseases. His blood electrolytes were slightly abnormal, which could well be due to the frequent vomiting the patient had at that time. I don't think that his electrolytes are necessarily related to his principal illness. His electrolyte imbalance was corrected by the administration of the proper electrolyte solutions.

L. E. PREPARATIONS

L. E. preparations were negative on two occasions and this would of course rule out lupus erythematosus, especially since his clinical picture was not at all characteristic for this disease. His persistently negative blood culture would tend to rule out subacute bacterial endocarditis. The gradual rise and decline of his blood urea nitrogen did not conform with a severe uremic condition. His chest x-ray suggested first an acute pulmonary edema and later a bilateral pneumonitis which was considered a manifestation of his uremia. However, many patients with uremia do not develop pneumonitis and I wonder if this explanation is a valid one.

The patient was treated with antibiotics, diuretics and digitalis. His electrolytes were improved by the intravenous administration of the proper fluids, and he began to improve slightly. He started to eat and most of his nausea and vomiting disappeared. His blood pressure remained elevated. Soon, however, he became more lethargic and expired some 20 days after admission, or approximately in the ninth week of his illness.

I think that the differential diagnosis of this patient's illness revolves around rheumatic fever, glomerulonephritis, subacute bacterial endocarditis, lupus erythematosus, and periarteritis nodosa, all of which belong to the group of collagen diseases. It is true that he had swollen, painful joints following a sore throat, but the interval between these symptoms seems too short for rheu-

matic disease. If he did have it, he must have gone into very rapid heart failure, and we cannot explain very well the severe degree of renal damage he apparently had.

As for subacute bacterial endocarditis, it is true that one positive blood culture was obtained, but this one showed a mixed flora and all subsequent cultures were negative. He did have petechiae and a heart murmur, but no splenomegaly. Patients with subacute bacterial endocarditis can go into rapid heart failure and also can have an embolic type of renal disease with renal failure. However, the lack of bacteremia and the rapid course of the disease in this patient are so contradictory that I hesitate to make this diagnosis even though it seems a good bet.

Lupus erythematosus can cause multiple system manifestations, but surely our patient did not show typical lupus symptoms. He had no skin lesions, which is not absolutely necessary; he had no severe pleurisy, and no polyserositis except for ascites which seems to be related to his liver condition. All his L. E. preparations were negative, and he did develop a severe leukocytosis, which is not observed in this disease.

ACUTE NEPHRITIS?

There remains a strong possibility that the patient suffered from acute nephritis superimposed upon a previous glomerulonephritis. His mother had stated that at the age of 2 he "swelled up all over." Now this could mean anything from hives to I don't know what. But a history of a child who has been so edematous that the parents were told by the doctor that he does not expect the child to survive, surely makes you think of the diffuse edema of nephritis in childhood.

The fact that his present symptoms followed so closely a sore throat which could have been streptococcal, makes you think that this could have been an acute exacerbation of a previous glomerulonephritis. However, his eyegrounds were entirely normal. This was attested to by two competent men, and I think it unusual for a man to develop uremia from glomerulonephritis without showing some eyeground changes. Besides his childhood episode seems questionable and cannot be relied upon. I also think that his illness was too rapidly fatal for a glomerulonephritis, that his symptoms were too manifold to fit this diagnosis.

The fifth possibility to be considered is polyarteritis nodosa, and among the factors which would agree with this diagnosis are, first, the extremely rapid course of his illness, and second, the known predominance of the disease in males of the age group between 20 and 40. It frequently has an onset which is similar to rheumatic fever with glomerulonephritis. It can develop also on the basis of sensitivity to penicil-

lin and other drugs. Joint pain is a very common symptom in this disease. Myalgia, which has not been mentioned in our patient, is very common too; so are petechiae, and of all the collagen diseases polyarteritis is noted especially for its diffuse renal involvement. It can cause hematuria and hypertension. As to whether it can cause hypertension without eye ground changes, I don't know, but surely this is more likely than to have uremia from glomerulonephritis without eyeground changes.

His cardiac enlargement and his systolic murmurs are quite in agreement with this diagnosis. Pulmonary infiltrations are not at all unusual and neither are nausea, vomiting and diarrhea, since this is a generalized disease of all vessels including those of the G.I. tract. Renal injury with gross hematuria, uremia, fever, weakness and weight loss—all these symptoms—fit into the clinical picture.

However, while I do think clinically that this man may have had periarteritis nodosa, I know of no way of making an accurate diagnosis short of biopsy, which was not done—either because this diagnosis was not considered or because the man was too severely ill. I would probably agree that in patients with this clinical picture the more likely diagnosis would be an acute exacerbation of glomerulonephritis. I do believe, however, that his symptoms fit the picture of polyarteritis nodosa and that is what I think he had.

GENERAL CLINICAL DISCUSSION

MEDICAL STUDENT: Where would you take the specimen for biopsy in order to verify your diagnosis?

DR. WALL: Frequently these people have a severe myalgia and the biopsy site of choice would be the gastrocnemius. Of course, you can be fooled by the biopsy too, and Dr. von Haam would be the first to admit this. Although you may see perivascular accumulations of inflammatory cells the lesion may not be necessarily polyarteritis.

DR. SCHIEVE: Do you consider 5 mg. of meti-corten® an adequate dose?

DR. WALL: Yes. It would correspond to 15 to 20 mg. of cortisone, which I consider sufficient.

CLINICAL DIAGNOSIS

1. Periarteritis nodosa.
2. Acute and chronic glomerulonephritis.
3. Uremia.

PATHOLOGIC DIAGNOSIS

1. Periarteritis nodosa.
2. Acute and subacute glomerulonephritis.
3. Septic myocarditis.
4. Healed rheumatic valvulitis.
5. Uremic pneumonia.

PATHOLOGIC DISCUSSION

DR. EMMERICH VON HAAM: We did not find much on the gross examination of the body. The skin showed a few ecchymoses and there was bilateral ankle edema. The peritoneal cavity contained about 500 cc. of clear fluid and each pleural cavity contained about 300 cc. of the same type of fluid. The heart was slightly enlarged and weighed 400 grams. Both ventricles were dilated and the mitral valve contained some small friable gray vegetations. The papillary muscles showed subendocardial hemorrhages and the myocardium was soft. The lungs were heavy and showed the areas of infiltration observed in the x-ray picture. We felt that it resembled patchy consolidation rather than simple edema.

The spleen was somewhat enlarged and showed a recent infarct. The liver was enlarged and pale and its appearance was compatible with parenchymatous degeneration. The intestinal wall was edematous. The stomach showed one large and two small recent ulcers. The adrenals together weighed 21 grams and showed cortical hyperplasia. The kidneys were large and weighed twice the normal weight. The surface was smooth and gray, mottled with numerous pinpoint petechiae. Both showed a few recent small infarcts. The renal parenchyma was soft, bulging and mottled. The bladder mucosa showed numerous petechiae. Examination of the brain was not permitted.

MICROSCOPIC EXAMINATION

Sections through the heart showed an old, partially hyalinized rheumatic valvulitis of the mitral valve and a recent myocarditis with small areas of focal necrosis. The latter was not of the rheumatic type but resembled more an acute septic or embolic myocarditis. Sections through the lungs showed marked desquamation of the alveolar cells with fibrinous exudate and hemorrhage in the alveoli, which is compatible with uremic pneumonia.

The ulcers of the stomach were sharply demarcated and the vessels at the bottom of the ulcers showed typical acute arteritis with thrombus formation and fibrinoid necrosis of the vessel wall. It undoubtedly points to the vascular origin of the ulcers. Similar vascular lesions were also observed in the wall of the gallbladder, in the spleen, pancreas, the periadrenal tissue and the kidneys. This of course explains the infarcts in the spleen and liver. In addition to the panarteritis, the kidneys showed severe acute and subacute glomerulonephritis with crescent formation and leukocytic infiltration of the glomeruli.

In summary we may then say that this patient died from the consequences of two diseases: a glomerulonephritis with uremia, and a widespread necrotizing polyarteritis. The question is now: Are both lesions interrelated and what if any role was played by the sore throat which

preceded their onset? The patient did not have any positive blood cultures after the first inconclusive report, nor did he have clinical evidence of septicemia such as chills and spiking fever, and in none of the infarcts did we see evidence of bacterial growth.

For this reason we can rule out a severe bacterial infection such as streptococcal sepsis and must think rather of certain allergic reactions which either appear spontaneously following one or repeated streptococcal infections or which may be induced by certain therapeutic measures. We observe the so-called sensitivity angiitis in patients who are treated with certain drugs, such as the sulfonamides or penicillin, which are either a foreign protein or which combine with proteins and thus acquire antigenic properties.

Certain differences between an idiopathic panarteritis or periarteritis nodosa and the sensitivity panarteritis have been pointed out by some authors. They are not very striking, but it has been stated that true periarteritis shows more skin and muscle lesions, while the sensitivity arteritis tends to involve more the vessels of the lung and of the parenchymatous organs.

In our case, the distribution of the lesions, the absence of skin nodules and of muscular lesions, and the fact that the patient developed the first symptoms seven days after he had had penicillin, make a strong argument for an acquired drug sensitivity as the basis for the panarteritis. I selected this case for our discussion because we may expect a more frequent occurrence of this chain of events with the increased use of antibiotic drugs. In most cases the results are good and the patient gets well quickly. Sometimes, however, things go wrong, and our case is a good example of it.

GENERAL DISCUSSION

DR. WALL: In spite of what has been written on the subject, we must confess that the clinical differentiation of periarteritis nodosa and sensitivity angiitis is extremely difficult. It is true that most polyarteritis patients have a more protracted course, while sensitivity angiitis is rather a fulminating and rapidly progressive affair. But that is only a general rule and may not be true in any individual case. Surely the history of antecedent administration of penicillin in this case is striking, but I know an awful lot of people with panarteritis who get penicillin because of some of their symptoms.

DR. SCHIEVE: Don't the glomerular lesions mean some form of nephritis?

DR. VON HAAM: The patient had undoubtedly a subacute glomerulonephritis, but I don't think that the uremia was severe enough to produce the necrotizing vascular lesions. The periarteritis definitely dominated the picture clinically and to me it suggests the possibility of an allergic basis for some of the glomerular lesions.

Franklin County Pelvic Cancer Delay Committee Report

By JOHN H. HOLZAEFEL, M. D.
Columbus, Ohio, Chairman

The Franklin County Pelvic Cancer Delay Committee met at the Columbus Health Center on July 19, 1956, at 12 o'clock. Two cases were presented.

Case 26: A 34 year old female noticed intermenstrual vaginal bleeding and foul discharge and two weeks later consulted her physician who gave her some medicine. No pelvic examination was done. She returned two weeks later and reported no improvement. Pelvic examination at this time revealed a lesion of the cervix strongly suggesting carcinoma. Referred to St. Ann's clinic. Patient was seen there three weeks later and a clinical diagnosis of epidermoid carcinoma of the cervix, Stage I, was made. Admitted to hospital for diagnostic study and treatment. She received a total dose of 7,000 R. to point A. by radium. Discharged to receive external therapy.

Comments: DR. WILLIAM E. CRISP: A pelvic examination, papanicolaou smear plus a biopsy should have been done if there was gross evidence of a suspicious carcinoma.

DR. FRANCIS GALLAGHER: Patient delay; two weeks from onset of symptoms until she saw her physician, and three weeks between second visit to physician and visit to clinic.

DR. JONATHAN BUSBY: Physician delay: two weeks between first visit and pelvic examination done at the second visit.

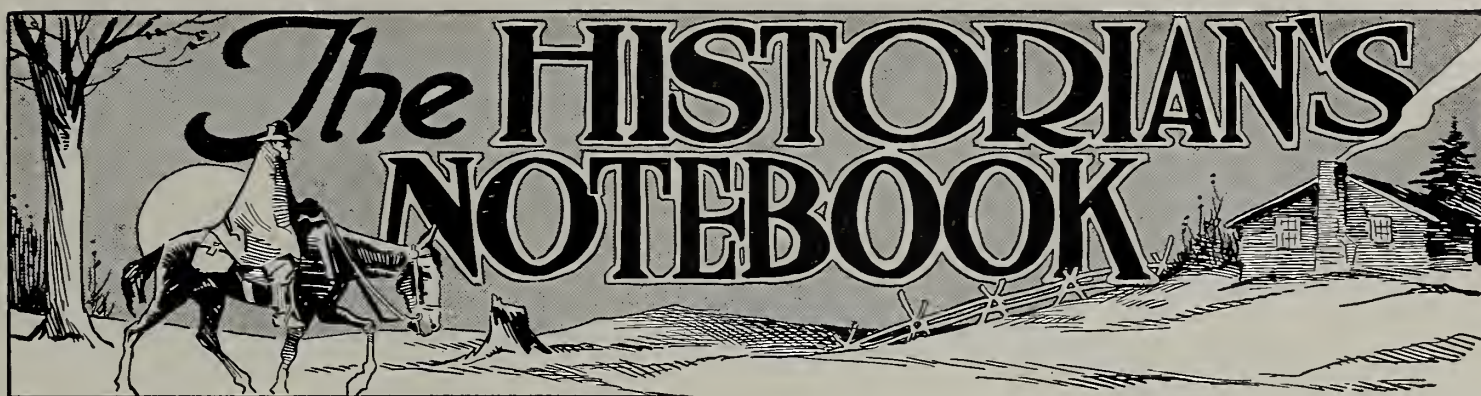
Discussion: If, when a patient is referred to a clinic, the physician would have his nurse call and make a definite appointment, delay as in this case could be cut down.

Case 27: This 29 year old white female was first seen in St. Ann's clinic with history of increasing menorrhagia for the last three months. She had noticed contact bleeding for several months before. Nine days before her clinic examination she was seen by her family physician. Because she was bleeding he gave her a "shot" and she was to return when the bleeding stopped. She returned in one week and examination revealed a cervical lesion on the anterior lip which was suspicious of carcinoma. Patient was seen in the clinic two days later and admitted to the hospital for diagnostic study and treatment. Clinical diagnosis was carcinoma of the cervix, Stage I. Pathologic diagnosis was epidermoid carcinoma of the cervix, grade IV. She had two applications of radium for a total dose of 6,304 R. to point A. She received 3,000 R. external therapy.

Comments: DR. JOHN H. HOLZAEFEL: Instead of treatment and a pelvic examination on the first visit, the patient received a "shot." The danger period is in the younger age group who interpret bleeding as an irregular period and thus we see the greatest time loss here.

DR. FRANCIS GALLAGHER: Patient delay of six to seven weeks.

DR. FRANK HUGENBERGER: Physician delay of one week which is negligible, but the reason is important. Once again a physician was reluctant to examine a bleeding woman.



Meetings of the Faculty of Starling Medical College in 1858

JONATHAN FORMAN, M. D.

IT is to be noted that meetings of the Faculty of a medical college 100 years ago were mostly devoted to trivia—repairs, bills, applications for honorary degree of M. D.,—simple rules of the conduct of the demonstrator of anatomy. These meetings were held at the homes of the respective members after office hours. In these minutes high hopes were expressed of founding a Society of Natural History. In addition the Starling Faculty was struggling with an unfinished building as a result of the naïve acceptance of the architect's estimate.—EDITOR.

Saturday, November 13, 1858.

"The Faculty of Starling Medical College met pursuant to a regular call. The minutes of the preceding meeting were read and adopted.

"Dr. Loving moved that Dr. Wormley's hour for lecturing be changed from 2 P.M. for the reason, as urged by Dr. Wormley, that chemistry is less interesting to students than the other branches of medicine and that in consequence they become tired and restless during his lectures, and further that the light is not sufficient for the satisfactory performance of the experiments necessary for illustration. The motion was discussed pro & con and finally carried.

"Dr. Hamilton moved that the College exercises on Wed. morning consist of a lecture by a professor of anatomy from 9 to 10 o'clock and that a clinic by the professor of surgery on practical medicine at the State Prison be held; that the exercises on Saturday mornings consist of a lecture by the Professor of Theory & Practice from 9 to 10 o'clock and that the remaining two hours be occupied by the Professor of Surgery in giving clinical instruction or otherwise as may seem fit and appropriate to himself. Adopted.

"Dr. Wormley said that hitherto he had recd. compensation for his services at the college—that nothing had as yet been said on the subject this year. He would inquire whether the Faculty

intended to allow him anything. Dr. Carter moved that a Committee of one be appointed to confer with the Dean with regard to the subject, that it may be ascertained whether Dr. Wormley shall receive compensation, and if it be decided that he is, then the amount may be fixed. Adopted. The Dean appointed Dr. Carter as the Committee of one on Dr. Wormley's salary.

"There being no further business for transaction the Faculty adjourned to meet at the office of Dr. Smith on Saturday evening, November 27, 1858.

"S. LOVING, Secy."

November 27, 1858

"The Faculty met pursuant to adjournment. Members present were the Dean, Doctors Hamilton, Carter, Loving and Wormley. Absent: Smith. Minutes of the preceding meeting were read and adopted.

"The Dean read a letter from Dr. Clarke, one of the students of the class, making application for an honorary degree of Doctor of Medicine for Dr. Reynolds of Beverley, Washington County, Ohio. On motion of Dr. Carter, the matter was ordered to remain with the Dean for the present, so that he may have an opportunity for obtaining references &c.

"Dr. Hamilton said he would be pleased to have the Faculty confer an honorary degree for Dr. Wortman of Muskingum County, also one upon Dr. Hodge of Tuscarawas County. The subject was discussed pro and con, and ordered to remain with Dr. Hamilton for the present. Dr. Hamilton was requested to correspond with Doctors Wortman and Hodge and inform them that they can be allowed to the examination for a degree on paying the fees for a course of lectures and the fees for graduation.

"Dr. Loving moved that Dr. Wormley be appointed to deliver the next Valedictory to the graduating class. Discussed and finally amended

by Dr. Hamilton, proposing that Dr. Smith shall deliver the valedictory and Dr. Wormley the next annual introductory address. On motion, the first section, or paragraph, of the motion of Dr. Loving, in the minutes of the last meeting, was repealed, the change of the hour of lecture not operating as well as was thought.

"There having been no further business for transaction, the Faculty adjourned, to meet at the Museum room of the College on Saturday evening, December 18th.

"S. LOVING, *Secy.*"

Saturday Evening, December 18, 1858

"The Faculty met pursuant to a regular call by the Dean. Present: all members. Minutes of the preceding meeting were read and adopted.

"The Dean presented applications from G. B. Russell and W. C. Keever, members of the class, for permission to be admitted to examination for degrees. Mr. Russell states in his application that he commenced his studies of medicine in 1852, that he has attended a course of lectures on practical anatomy by Wm. Clendenning, demonstrator of anatomy of the Ohio Medical College in Cincinnati, also a course of clinical lectures at the Commercial Hospital in Cincinnati by the professors of the Ohio Medical College. Also that he had been practicing with his preceptor since the Spring of 1855. He has attended lectures here during the season. Discussed pro and con and ordered to be laid on the table for further consideration, collection of references &c.

"Mr. Keever states in his application that he has been practicing four years.

"Dr. Carter moved that the Dean take both these applications and examine them carefully and that, if it can be ascertained, that the gentlemen can comply with the usual terms and regulations necessary under such circumstances, they be admitted to an examination. Carried.

"The Dean inquired how many days vacation should be accorded during the coming holidays. Dr. Wormley moved that the vacation commence on Thursday December 23rd and close Jan. 3d, Monday. Dr. Carter offered to amend by commencing the vacation on Friday, Dec. 24 at noon and closing it on Monday, the 3d January at noon. Amendment accepted and motion carried.

"Dr. Hamilton moved that the Committee on the Museum be directed to call a meeting of persons interested in Natural History on Thursday, December 30 to 3 P.M. for the purpose of consulting as to the propriety of forming a Society of Natural History in connection with the college. Motion carried.

"The Dean moved that a committee be appointed to ascertain an estimate of the cost of finishing the main stairway of the college building (the East stairway) plastering the tower, and finishing, nailing &c. Dr. Carter moved that

the Committee on the Museum be instructed to take the matter in charge. Carried.

"Adjourned to meet January 8, 1859.

"S. LOVING, *Secy.*"

Dr. Charles Henry Wetmore Pioneer Physician

BY GILBERT F. DODDS

*Research Associate of the Franklin
County Historical Society*

For more than 100 years there stood on the west side of the old Columbus and Worthington turnpike a familiar landmark—the lifetime residence of Dr. Charles Henry Wetmore, pioneer physician and business man of Franklin County. Dr. Wetmore's social disposition and hospitable nature made his home—Locust Grove—widely known and a favorite resort of friends and travelers.

Dr. Wetmore was born in Hartford, Connecticut, in 1783. Following graduation at Yale University he studied medicine and began the practice of his profession in New York City. There in 1814, the doctor met and married Eliza Rathbone, fifth daughter of John Rathbone, a retired merchant of New York City who had received in repayment of loans to the government for the construction of the Erie Canal and for service in the Revolutionary War, four 1,000 acre tracts of land in what is now Sharon Township. It was to look after this land that Dr. Wetmore decided to move to Ohio.

In November of 1819, Mr. and Mrs. Rathbone set out with the young Wetmore couple in a traveling carriage, with a man and maid servant and the two small Wetmore children. The party arrived at Demans Adams Hotel, Worthington, December 18, 1819, after a six week journey. The Wetmores soon built the home that was to be known throughout the countryside as Locust Grove.

Dr. Wetmore's practice took him on a circuit from Alum Creek to the Scioto River and from the southern boundary of Delaware County to Darby Plains. He often was absent from home many days during which time Mrs. Wetmore amused herself with her music. Some of the notations in the accounts of Dr. Wetmore are as follows:

Demans Adams, to visit for wife, twenty-five cts;

Ezra Griswold, visit for son, twenty-five cents;

Bishop Chase, to visit emetic tartar for son, extracting tooth for wife, fifty-cents.

On November 13, 1820, Dr. Wetmore moved from Worthington with his family to a log house which he had built on or near the present settlement of Beechwold. It was there that he later built a two-story homestead which was known to all regular travelers between Columbus and Worthington.

THE VOTE IS THE PAYOFF!

OHIO PHYSICIANS, more than 10,000 strong, members of their families, their neighbors, and other intelligent, thinking citizens, have a big stake in the General Election, November 6, for, as Raymond Moley stated it in his book, *How To Keep Our Liberty*: "The fight for liberty is unending. In the calendar of politics there are no holidays."

What can, and should, the physician, his family, his neighbors, his friends, do about November 6—do between now and November 6?

Moley says: "The fight * * * cannot be won by the timid and noncommittal. People must forego convenience, and security from criticism. They must get into politics personally, directly and actively. They must be for someone and against someone, despite the consequences. Citizen action must be militant. * * * There is absolutely no substitute for personal, face-to-face contact with the voter." Moley makes an ardent plea that people who care to get into the highways and byways and talk up the candidates who are qualified for the jobs they are seeking.

Continuing, Moley says: "All the effort, money, and ingenuity devoted to selecting good candidates, arguing for a cause, writing, printing, and distributing literature, making speeches, and organizing rallies are in vain, if on Election Day voters do not vote. For the vote is the payoff, the power and the promise of the future. That, of course, means getting out the right kind of voters."

Key Ohio physicians—officers and legislative chairmen—of practically all Ohio's County Medical Societies have at their disposal data on most of the candidates for most of the important public offices to be filled on November 6. Pre-election conferences have just been completed in each of the 11 Councilor Districts.

Individual physicians who want to work for good candidates should go to the officials of their County Medical Society for information and advice.

Members of the local Woman's Auxiliaries who want to work for good candidates should get information regarding candidates from officials of the medical society of their counties.

Physicians and members of the auxiliary should take part in activities aimed at assisting the disabled and sick to vote by means of disabled voters' ballots.

Between now and November 6, the job is to get the right kind of voters interested and to see that they have the facts about the candidates.

Remember: The vote is the payoff!

Proceedings of The Council . . .

Heavy Docket Considered at Granville Meeting; Policy Adopted on Military Dependents Medical Care Program; Reports From Committees Acted On

THE ANNUAL Fall conference of the Council, Ohio State Medical Association, with AMA delegates and a number of committee chairmen as guests, was held at the Granville Inn, Granville, Ohio, on Friday evening, September 14, and Saturday and Sunday, September 15-16, 1956. All members of The Council were present.

After introducing the invited guests, Dr. Meiling, the president, asked for a motion for approval of the minutes of meetings of The Council held on June 2-3, 1956. By official action, the minutes of those sessions were approved.

BALLOT RATIFIED

By official action The Council ratified the ballot taken by mail, electing Dr. Frank H. Mayfield, Cincinnati, to the office of Councilor of the First District, succeeding Dr. Charles T. Atkinson, Middletown, resigned.

On motion by Dr. Artman, chairman of the Committee on Auditing and Appropriations, seconded and carried, The Council confirmed action of that committee, authorizing the employment of Mr. Charles W. Edgar, Jr., Springfield, as administrative assistant in the Columbus Office and action of the Committee on Auditing and Appropriations in authorizing increases in salaries of certain members of the Columbus Office staff.

MEMBERSHIP DATA

The Executive Secretary reported on membership as follows: OSMA membership as of September 13, 1956, 8,702; compared to a total membership of 8,633 as of December 31, 1955. Of the total number of OSMA members as of September 13, 1956, 7,721 were affiliated with the American Medical Association; compared to a total of 7,512 of the 1955 OSMA members. A breakdown of membership by counties and councilor districts was distributed to each member of The Council.

PRO RATA DUES AUTHORIZED

By official action, The Council authorized pro-rating of dues for new members in 1957 as follows: Dues for a new member affiliating in the third quarter of the year, \$15.00; dues for a new member affiliating in the fourth quarter of the year, \$10.00.

DUES FOR MEDICAL OFFICERS

The Council, by official action, established the following procedure with respect to members on

extended active duty in the military service or in the U. S. Public Health Service:

"1. State Association dues for 1957 shall be waived for members on extended active duty in the military service or U. S. Public Health Service.

"2. State Association dues for 1957 shall be waived for physicians who were members of the Association in 1956 and who enter such services during the calendar year 1957 before the payment of 1957 dues.

"3. A refund of membership dues will not be made if a member enters such services in 1957 after his 1957 dues are received at the Columbus Office of the Association.

"4. The secretary-treasurer of each county medical society shall be requested to cooperate with the Columbus Office in assembling the names of physicians entitled to waiver of dues under the foregoing provisions."

DUES FOR INTERNS, RESIDENTS

By official action, The Council adopted the following statement of policy relating to dues for interns and residents affiliating with the State Association during the calendar year 1957:

"Annual Ohio State Medical Association dues for a physician serving a hospital internship or residency during the first five years following graduation from medical school (excepting the time spent in military service), who meets the membership eligibility requirements of the Ohio Medical Association and who is accepted into membership by a component medical society, shall be \$7.50. Such intern or resident member shall be offered a subscription to *The Ohio State Medical Journal* at one-half the regular subscription rate."

Certificates and gold emblems for new 50-year physicians were distributed to members of The Council, who will get in touch with the county societies involved with respect to awarding the certificates and emblems.

AMENDMENTS APPROVED

An amendment adopted by the Scioto County Medical Society on July 9, 1956, to Section 2, Chapter 2 of the By-Laws of that society, pertaining to time of meetings of such society, was approved by The Council by official action.

By official action, The Council approved an amendment to Chapter 5, Section 2, of the By-

Laws of the Huron County Medical Society, pertaining to annual dues, adopted by that society at its September meeting.

A revised constitution and by-laws, adopted on September 4 by the Summit County Medical Society, after preliminary conferences and approval of the document by the Judicial and Professional Relations Committee of the State Association, was then considered. Dr. Dooley, chairman of the Judicial and Professional Relations Committee, Mr. Stichter and Mr. Nelson commented on the revised document; stated that revisions suggested by the committee had been complied with; and recommended to The Council that the revised document be approved. By official action, the revised Summit County Medical Society constitution and By-Laws were approved.

Mr. Stichter and Mr. Nelson reported to The Council that work is still being done on the new proposed "model" constitution and by-laws for county medical societies and that they hoped to have a completed proposal for consideration by the Judicial and Professional Relations Committee at an early meeting.

1957 ANNUAL MEETING

Dr. Ernstene, chairman of the Committee on Scientific Work, and the Executive Secretary presented detailed reports on plans for the 1957 Annual Meeting in Columbus, May 14, 15, 16, Veterans Memorial Building, as reflected in the minutes of that committee which met on August 26 and September 9.

By official action, the actions and recommendations of the Committee on Scientific Work with respect to next year's meeting were officially approved and the committee complimented on its activities.

In addition, The Council took specific action on the following Annual Meeting matters:

INDUSTRIAL MEDICINE SECTION CREATED

Authorized the appointment of Dr. Rex H. Wilson, Akron, and Dr. James P. Hughes, Columbus, as chairman and secretary of the newly created Section on Industrial Medicine.

Authorized the president to name a chairman for the Section on Radiology, after consultation with the president of the Ohio State Radiological Society, to take the place of Dr. Frank Riebel, Columbus, resigned.

Advised the committee not to arrange for television programs at the 1957 Annual Meeting.

Authorized the Executive Secretary to proceed immediately to secure speakers and panelists for certain presentations on legal and economic subjects as a part of the Annual Meeting program.

COMMITTEE ON SCIENTIFIC EXHIBITS

Confirmed the appointment by the president and the chairman of the Committee on Scientific

Work of the following as members of the long-term Committee on Scientific and Educational Exhibits: Dr. Geo. J. Hamwi, Columbus, chairman, five years; Dr. Harvey C. Knowles, Cincinnati, four years; Dr. A. D. Nichol, Cleveland, three years; Dr. Robert E. Zipf, Dayton, two years; Dr. Edwin H. Ellison, Columbus, one year.

"MEDICARE" PROGRAM

The Council then considered the request of the American Medical Association that the Ohio State Medical Association cooperate with the United States Department of Defense in establishing and operating a medical care program in Ohio for dependents of military personnel.

Dr. Martin and Mr. Saville made detailed reports on a conference held at the AMA headquarters in Chicago on the weekend of July 28-29. They reviewed material which had been placed in the hands of members of The Council prior to this meeting. Mr. Saville and Mr. Nelson also gave a report on a conference held at St. Paul of representatives of a number of state medical societies for the purpose of discussing this program.

STATEMENT OF POLICY

After a great deal of discussion and a long question and answer period, The Council, on motion duly made, seconded and carried, adopted the following statement of policy on this subject:

"The request of the United States Department of Defense that the Ohio State Medical Association cooperate in setting up and operating a medical care program in Ohio for dependents of military personnel ("Medicare"), provided for by Public Law 569, 84th Congress, has been thoroughly considered by The Council of the Ohio State Medical Association.

"In the interests of national defense and security, The Council, acting officially for the Ohio State Medical Association, hereby declares:

"1. The Ohio State Medical Association will cooperate with the Department of Defense in establishing and operating a "Medicare" program, provided that a satisfactory agreement on regulations and administrative details can be worked out between the Association and the Department of Defense.

"2. The Ohio State Medical Association will act as the negotiating and contracting agency on behalf of the medical profession of Ohio.

"3. Ohio Medical Indemnity, Inc., is hereby designated as the choice of the Ohio State Medical Association as its administrative and fiscal agent, Ohio Medical Indemnity, Inc., to be paid by the government for the actual costs incurred by it in performing such administrative and fiscal services.

"4. The President of the Ohio State Medical Association is authorized to appoint a negotiating committee which shall confer with represen-

tatives of the Department of Defense on a 'Medicare' program. Such committee is hereby empowered to execute on behalf of the Association an agreement, subject however to approval thereof by The Council, with the Department of Defense providing for the establishment and operation of a program in Ohio.

"5. The committee authorized in Paragraph No. 4 is empowered to formulate a medical and surgical fee schedule and present it as a part of a 'Medicare' agreement with the Department of Defense.

"6. The President of the Association, further, is authorized to name a committee to serve the Association in an advisory capacity to Ohio Medical Indemnity, Inc., on 'Medicare' administrative details."

COMMITTEE INSTRUCTED

The Council, by official action, instructed the negotiating committee to use the OMI preferred indemnity contract as one of its criteria for the fee schedule and not to approve any provision in a contract with the government which would be in conflict with the current policy of the Ohio State Medical Association in opposition to payment-in-full insurance contracts.

In addition, The Council, authorized the negotiating committee to make use of the services of Mr. Stichter, legal counsel, in its contacts with representatives of the government and instructed the Executive Secretary to send to all members of The Council a copy of the fee schedule nomenclature booklet prepared by the Department of Defense, together with copies of the OMI preferred contract, Workmen's Compensation Fee Schedule, Veterans Administration Fee Schedule, and an Aid for the Aged Fee Schedule.

PERSONNEL OF COMMITTEE

President Meiling appointed the following members of The Council as members of the negotiating committee: Dr. Martin, chairman, Dr. Hudson, Dr. Mayfield, Dr. Artman, Dr. Hopkins, and Dr. Petznick.

Dr. Dooley made a report for the Judicial and Professional Relations Committee. He advised that a proposed new constitution and by-laws formulated by the Belmont County Medical Society has been reviewed by the committee and returned to that society with certain suggested changes. He said it is anticipated that such changes will be adopted and that the new document will be before The Council for official action at an early meeting.

ETHICAL QUESTION

Dr. Dooley reported that the committee had considered the following letter from a member of the Association:

"While having a discussion with a group of physicians regarding the handling of occupa-

tional injuries by physicians who are full-time employees of a company, several questions were raised on which I hope you can give some answers.

"Can a physician employed by a company which is insured with the Industrial Commission handle occupational injuries for which he files fee bills with the Commission? Then on receipt of the money turn it over to his employer without jeopardizing the employer's status as 'practicing medicine as a corporation?'"

"Can a physician as above, file claims with the Industrial Commission and on receipt of the money keep it without having such action as considered unethical or illegal?"

"Is it ethical for such a physician as described above to turn in money he receives for treating occupational injuries back to the company?"

"Can you give me an idea as to the accepted practice of physicians who are full-time employees of corporations who are insured with the Industrial Commission?"

"Any counsel or answer you can give to the above questions will be deeply appreciated."

POLICY ADOPTED

After a thorough discussion of the letter and a study of all the ramifications, Dr. Dooley reported that his committee had adopted the following statement of policy and recommends that it be approved by The Council:

"1. It would not be unethical for a physician employed by a company which is covered by the State Workmen's Compensation Fund to submit bills to the Bureau of Workmen's Compensation for payment for medical or surgical services rendered in approved Workmen's Compensation cases.

"2. It would not be unethical for a physician to enter into an agreement with a company whereby the company would agree to pay him a specified annual amount in addition to fees which he may receive from the Bureau of Workmen's Compensation.

"3. It would be unethical for a physician to enter into an agreement with a company whereby he would agree to turn over to, or share with, the company, fees received by him for professional services to Workmen's Compensation claimants or other persons.

"4. It would be illegal for a company to enter into an agreement such as that described in Paragraph No. 3 for the reason that it would be a violation of the statute prohibiting a corporation from engaging in the practice of medicine.

"5. Responsibility for investigating such matters, and taking whatever action may be indicated, rests with the county medical so-

ciety, having jurisdiction over the physician or physicians involved."

By official action, The Council approved this portion of the committee's report.

CORPORATE PRACTICE QUESTION

Dr. Dooley then commented on a communication received from the Marion Academy of Medicine on the matter of corporate practice of medicine which had been considered by his committee.

Dr. Dooley stated that his committee felt that more information would be necessary before it could render a decision on this question. He said that the committee had asked the Executive Secretary to secure such information for consideration by the committee at its next meeting.

This portion of the committee's report was approved by Council by official action.

CODE OF RELATIONSHIP

Dr. Dooley and Mr. Stichter reported that the committee has just about concluded its work on the formation of a proposed model code of relationship between physicians and lawyers, which could be used by county medical societies and county bar associations as the basis for local agreements. Mr. Stichter stated, however, that Mr. Earl Morris, president of the Ohio State Bar Association, in conversations with Dr. Meiling and with him (Mr. Stichter), had suggested the possibility of conferences on the part of committees of the State Bar Association and the State Medical Association on this particular question. Mr. Stichter said that he had been invited to attend a meeting of a Bar Association committee to be held within the next several days at which this subject would be discussed.

By official action, Mr. Stichter was authorized to meet with the Bar Association Committee and the Judicial and Professional Relations Committee was requested to delay final action on the proposed model code of relationship, pending possible discussions with a committee of the State Bar Association.

At the conclusion of Dr. Dooley's report, The Council, by official action, thanked the committee for its work and approved the report as a whole.

COMMITTEE ON MATERNAL HEALTH

Mr. Page made an oral report for the Committee on Maternal Health. He stated that the committee had met five times this year; had collected data on 126 maternal deaths occurring in 1955; had reviewed 79 of these cases. Mr. page referred to the educational material which the committee is sponsoring in *The Ohio State Medical Journal*, the first of the series of articles having appeared in the September issue. Also, Mr. Page reported that Dr. Meiling, at the request of The Council, had appeared before the Ohio Public Health Council on June 23 and presented the recom-

mendations of the Ohio State Medical Association on the proposed maternity hospital regulations. He stated that the regulations were adopted, becoming effective July 16, 1956, and that practically all of the recommendations of the Ohio State Medical Association had been given favorable consideration.

At the conclusion of Mr. Page's report, The Council, by official action, thanked the Committee on Maternal Health for its work and approved the report as a whole.

AMEF PROGRAM IN OHIO

Reporting for the Committee on American Medical Education Foundation, Mr. Saville reported that 649 Ohio physicians had contributed \$30,192.50 to the AMEF campaign in 1955 and that an additional \$92,472.65 had been contributed by 2,314 medical alumni in Ohio directly to their medical schools.

At the conclusion of this report, President Meiling announced that he has appointed Dr. Merrill D. Prugh, Dayton, a past-president of the Ohio State Medical Association, as Ohio AMEF chairman, succeeding the late Dr. Wm. M. Skipp, Youngstown. Dr. Meiling urged members of The Council to actively promote the 1956 campaign in their respective districts. (See page 1086 this issue of *The Journal*.)

COMMITTEE ON RURAL HEALTH

A report for the Committee on Rural Health was presented by Mr. Page. The highlights of the report were as follows:

The committee on August 1 selected the 1956 recipient of the 8th Annual OSMA Rural Medical Scholarship, namely, Edwin L. Eakin, Canal Winchester, who has entered the University of Cincinnati College of Medicine.

The committee is developing a more active working relationship with the 4-H Clubs, believing that a proper medical and health attitude on the part of farm youngsters is very important. The committee plans to cooperate with the 4-H Clubs on many of their activities, including assistance on the 4-H Club health improvement contest. This would include assistance in the judging of the contest; formulation of revised physical education blanks; development of a personal and family health record card for use by members; sponsoring the male winner of the annual 4-H health improvement contest at the national 4-H Club Conference.

The committee hopes soon to take definite action establishing a general practice preceptorship program on a limited scope, subject to the approval of the medical schools involved.

The committee again will sponsor in the Spring of 1957, a series of lectures on general practice in small areas for the seniors at Ohio State University and the University of Cincinnati College of Medicine.

Cooperation between the committee and the

Ohio Farm and Home Safety Committee is being developed.

By official action, the report of the committee was accepted and the committee thanked for its fine program of activities.

PRE-ELECTION CONFERENCES

Dr. Mayfield, chairman of the Committee on Legislation, and Messrs. Nelson, Saville and Page reported on the 11 pre-election conferences held during the past two weeks in the councilor districts. They stated that the meetings were well attended and that the interest on the part of those attending was enthusiastic. However, they did say that there is a feeling in many areas that citizens generally are not taking as much interest in the forthcoming November 6 election as in recent years. Members of The Council were urged by Dr. Mayfield and Dr. Meiling to do what they can to arouse greater interest among the physicians in their respective districts and to urge all members to go to the county society officers and legislative chairmen for information and advice relative to candidates.

ANESTHESIA QUESTION

The Council then considered a resolution adopted on September 8, 1956, by the Ohio Society of Anesthesiologists, requesting the Ohio State Medical Association to ask Ohio Medical Indemnity to make certain changes in its preferred contract with respect to the administration of anesthesia by nurses.

After considerable discussion, by official action, The Council referred this question to the Committee on Public Relations and Economics with instructions to arrange for a conference of all persons concerned, hear testimony and formulate a report for consideration by The Council at some future meeting.

MALPRACTICE DATA

The Executive Secretary presented a report on progress to date in securing malpractice data from the various counties. He stated that so far 13 counties have sent in reports, most of them reporting that no malpractice suits have been filed. No official action was taken, but it was the unofficial sentiment of members of The Council that the program should be continued for the remainder of the year even though very little information of any value has been assembled. The president suggested that members of The Council bring this matter to the attention of their respective county societies in an effort to secure reports from more counties between now and the end of the year.

WORKMEN'S COMPENSATION

Dr. Worstell reported to The Council that, as yet, the Bureau of Workmen's Compensation and the Industrial Commission have not acted on the suggested changes in the medical and surgical

fee schedule, submitted on June 20 on behalf of the Ohio State Medical Association. By official action, The Council instructed Dr. Worstell to contact the proper officials on this matter in an effort to expedite action.

The Executive Secretary reported that he had been advised that the Bureau of Workmen's Compensation is considering the adoption of a regulation which would make it unnecessary for a physician to file x-ray films with the bureau, providing the physician files a complete interpretation and will assume the obligation for retention of the films in his own files for a period of ten years, making them available on request during that time to officials of the bureau for review and as evidence in litigation. The Council took no action on this but individual members pointed out that this would involve very definite enforcement problems.

At the conclusion of his report, Dr. Worstell stated that he felt some consideration should be given to an increase in the fee allowed in the Veterans Administration fee schedule for examinations by specialists. The president referred this matter to the Committee on Medical Care of Veterans for consideration at the next meeting of that committee.

TEMPORARY LICENSE QUESTION

The Executive Secretary asked for instructions with regard to a question which has been pending for some time, namely, a proposal that legislation be considered to provide for a temporary state license for interns and residents in order to give such physicians a more substantial legal status in Ohio. By official action, The Council authorized the president to refer this matter to the proper committee for study and recommendation. The president referred the question to the Committee on Education.

PROPOSED DIABETES PROGRAM

Consideration was given to a letter dated September 7 by Dr. Frederick H. Wentworth, Acting Chief, Division of Chronic Diseases, Ohio Department of Health, asking the Association to approve a diabetes case finding program under consideration by the Ohio Department of Health.

By special invitation, Dr. Wentworth appeared before The Council to discuss the proposed program and answer questions. After an extensive discussion, on motion duly made, seconded and carried, the president was authorized to refer the matter to a committee and he referred the matter to the Committee on Public Relations and Economics.

INSURANCE FORMS

A letter from the Health Insurance Council, asking the Association to reconsider its action of June 3 regarding an insurance claim form for use in Ohio, was presented to The Council. The letter asked that The Council's action be postponed so that further testimony could be offered

by representatives of the Health Insurance Council.

By official action, The Council instructed the Committee on Public Relations and Economics to hold another meeting on this subject and to invite representatives of the Health Insurance Council to send representatives to such meeting. Such action implied that nothing should be done to implement the action of June 3 until after the committee had reported to The Council on the new conference with representatives of the insurance industry.

AMA MEETING

AMA delegates present reported on activities at the June meeting of the AMA in Chicago, with special reference to the two resolutions which had been presented by the Ohio delegation. It was pointed out that Dr. Meiling had been made chairman of a special investigating committee on the question involved in one of the resolutions, namely, use of radium or radioactive isotopes. With respect to the second resolution, it was reported that its provisions had been covered in the report of the Stover Committee on Hospital Accreditation and the action of the House of Delegates on that question.

REPORTS BY COUNCILORS

Members of The Council then reported on activities in their respective districts.

Dr. Meiling announced that the next meeting of The Council would be held on Saturday afternoon, December 15, starting at 2 o'clock, with a session on Sunday, December 16, if necessary.

There being no further business, The Council adjourned.

Attest: CHARLES S. NELSON,
Executive Secretary.

Men Show Preference for Marriage To the Tune of 39 Million

Marriage as a way of life is at peak popularity among American men. In number, American husbands have reached a record high, totaling nearly 39,000,000 in the civilian population alone.

These facts were reported by the Metropolitan Life Insurance Company which further revealed: That about 95 per cent of married men under age 65 are gainfully employed; one-fourth of present-day husbands are under 35; another fourth are between 35 and 44; the number 65 years old or older is 11 per cent of the total and is growing rapidly; four-fifths of the families where the husband is 25 to 34 have at least one child, and nearly one-quarter have three or more. Relatively large families are even more popular where the husband is in the age group 35-44. In about one-fourth of the families both husband and wife are employed.

Contraindications in Reserpine Cited in FDA Letter

Physicians who have a standing supply of reserpine or drugs containing that product may desire to contact their pharmaceutical supply houses for information on a Federal Food and Drug letter concerning contraindications.

The FDA letter, sent to all drug houses, states that contraindications show the safe dosage level of long term outpatient maintenance is lower than originally recommended. The letter also contains recommended dosage maximum.

A number of firms marketing this drug have voluntarily reduced the dosage they are recommending and have added additional warning statements in their literature to physicians.

Some Recent Articles on Civil Defense

Physicians in key civil defense positions or those who wish to prepare talks on this subject will find the following list of recent articles helpful. They are recommended to physicians by the Council on Civil Defense of the American Medical Association:

"A Message from the AMA," *U.S. Armed Forces Medical Journal*, Vol. VI, No. 10, and Vol. VI, No. 11.

"Hospital Disaster Plan Check List," State of California Office of Civil Defense, Medical-Health Services Division.

"Operation Scramble," St. Louis County Hospital, St. Louis, Missouri.

"Hospitals in the Flood Crisis," by Mr. Arnold A. Rivin, *Journal of the American Hospital Association*, October, 1955.

"Emergency Hospital Plan," Dade County Civil Defense Council, Miami, Florida.

"Muskegon County Medical Plan—Civil Defense and Red Cross," Muskegon, Michigan.

Postgraduate Gastroenterology

The American College of Gastroenterology announces that its annual course in postgraduate gastroenterology will be given at The Roosevelt, New York City, October 18, 19, 20. The course will again be under the direction and co-chairmanship of Dr. Owen H. Wangenstein, Professor of Surgery of the University of Minnesota Medical School, who will serve as surgical co-ordinator and Dr. I. Snapper, Director of Medical Education, Beth-El Hospital, Brooklyn, N. Y., who will serve as medical co-ordinator. Those interested in enrolling should write to the American College of Gastroenterology, Department P. G., 33 West 60th Street, New York 23, N. Y.





ACHROMYCIN*

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for prophylaxis and treatment of

obstetric infections

Posner and his colleagues¹ have reported on the use of tetracycline (ACHROMYCIN) in 96 cases of obstetric complications, including unsterile delivery, premature rupture of the membranes, endometritis, parametritis, and other conditions. They conclude that this antibiotic is ideally suited for these uses.

Other investigators have shown ACHROMYCIN to be equally useful in surgery and gynecology and virtually every other field of medicine. This outstanding antibiotic is effective against a wide variety of infections. It diffuses and penetrates rapidly to provide prompt control of infection. Side effects, if any, are negligible.

Every gram of ACHROMYCIN is made in Lederle's own laboratories and offered *only* under the Lederle label—your assurance of quality. It is available in a *complete* line of dosage forms, including

ACHROMYCIN SF

ACHROMYCIN with STRESS FORMULA VITAMINS. Attacks the infection, bolsters the patient's natural defenses, thereby speeds recovery. Especially useful in severe or prolonged illness. Stress formula as suggested by the National Research Council.

SF Capsules, 250 mg.

SF Oral Suspension, 125 mg. per teaspoonful (5 cc.)

 For more rapid and complete absorption. Offered only by Lederle!

¹Posner, A. C., *et al.*; Further Observations on the Use of Tetracycline Hydrochloride in Prophylaxis and Treatment of Obstetric Infections, *Antibiotics Annual* 1954-55, pp. 594-598.



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Fall Postgraduate Courses . . .

Excellent Array of Programs Has Been Arranged by District Societies And Other Organizations; Doctors Have Good Choice of Subject Matter

DISTRICT meetings of physicians has long been a custom in areas of Ohio and this custom is being continued this Fall with some excellent programs arranged for doctors. These programs are within easy reach for physicians in their respective areas. With the Fall also come many local meetings that have taken on special significance because of the special programs arranged.

Some of these programs have already been held, as announced in last month's *Journal*. Others were too close to the publication date of this issue to be included. However, a number of excellent programs are still pending and offer worthwhile discussions for physicians in everyday practice.

Here are the programs announced to *The Journal*:

October 17—Northwestern Ohio Medical Association, Bowling Green.

October 18—Eighth Councilor District Meeting, McConnelsville.

October 18—Ninth Councilor District Meeting, Ironton.

October 24—Sixth Councilor Postgraduate Day, Youngstown.

October 24—Cleveland Clinic Postgraduate Program, Cleveland.

November 3—Ohio Academy of General Practice, Seminar on Hypnosis, Columbus.

November 1—St. Luke's Hospital Postgraduate Symposium, Cleveland.

November 7—Ohio State University, EENT Postgraduate Conference, Columbus.

* * *

Northwestern Ohio Physicians To Meet In Bowling Green, October 17

The Northwestern Ohio Medical Association will hold its annual meeting in Bowling Green on Wednesday, October 17, Dr. Henry B. Larzelere, Toledo, president of the organization, announced.

This is one of the traditional meetings of Ohio and is backed by an organization whose history goes back many generations. This will be its 112th scientific assembly. The association comprises physicians of the Third and Fourth Councilor Districts.

Six Category I hours have been awarded this meeting for members of the Ohio Academy of General Practice.

The program will be held in the Recreation Hall of the Administration Building, Bowling Green

State University. Registration begins at 9:15 a. m. with the program starting at 9:50.

The program has been announced as follows:

MORNING SESSION

Welcome by Dr. John V. Pilliod, president of Wood County Medical Society.

Infectious Diseases and Their Present Day Treatment, Dr. Paul A. Bunn, University of Syracuse Medical School.

What Cardiovascular Surgery Offers the Practicing Physician, Dr. Robert P. Glover, chief of thoracic surgery, Presbyterian Hospital, Philadelphia.

The Role of the Community Hospital in Disaster Planning, Anthony W. Eckert, director, Perth Amboy General Hospital, Perth Amboy, N. J.; Moderators, Dr. Charles Wohl and Dr. Orrin C. Keller.

Luncheon and Business Meeting, The Commons Bldg.

Reports and Comments.

Election of Officers.

Discussion of Organization Matters—Dr. James R. Jarvis, Councilor of the Third District; Dr. Paul F. Orr, Councilor of the Fourth District, and Mr. Charles S. Nelson, Executive Secretary, Ohio State Medical Association.

AFTERNOON SESSION

Abdominal Emergencies in Infancy, Dr. H. William Clatworthy, associate professor of surgery, Ohio State University College of Medicine, Columbus.

Clinical Applications of Available Laboratory Blood Tests, Dr. Robert L. Wall, assistant professor of medicine, Ohio State University College of Medicine.

Adjournment to the new Wood County Hospital for coffee and refreshments. Subject: **How Does This Hospital Plan for Mass Casualties?** Hostess, Miss Anna Belle Kinney, R. N., administrator.

* * *

Eighth District Meeting To Be Held At Rocky Glen, October 18

A custom of long standing will be followed this year when physicians of the Eighth District meet for a program at Rocky Glen Sanatorium in McConnelsville, on Thursday, October 18. All physicians of the area are invited.

A special feature of the meeting will be a tribute to Dr. Edgar C. Jones, colonel, U. S. Army,

retired, native of Morgan County who returned to McConnellsville in 1945 after 37 years of service in Medical Corps. Dr. Jones will receive the 50-Year Pin and Certificate of the Ohio State Medical Association.

Refreshments and a buffet style repast will follow the program.

Officers of the Eighth District organization are Dr. A. M. Kelley, president, and Dr. C. R. Reed, secretary, both of Lancaster. Dr. W. D. Monger, also of Lancaster, is Eighth District Councilor.

* * *

Ironton To Be Scene of Ninth District Meeting on Thursday, October 18

The Lawrence County Medical Society will be host to physicians of the Ninth District with a program in Ironton, on Thursday, October 18. This is the first of such meetings in the district in several years, and officers are going all out to make it a successful one.

Key program speaker for the occasion will be Dr. William G. Myers, research professor of medical biophysics and director of the Division of Medical Physics and Radioisotopes at Ohio State University College of Medicine. Dr. Myers, in addition to being a doctor of medicine, holds the degree of Ph.D. in physical chemistry. His background in nuclear fission gave him a prominent part in the early atomic explosion tests in the Pacific, and he has studied extensively medical aspects of the atomic age under the Army medical program.

Dr. Myers will discuss "Medicine in the Atomic Age." Arrangements were under way as this issue went to press for a second speaker, whose name will be announced later.

Registration will begin at 1:00 p.m. in the MacArthur Hotel on Route 52, Ironton. The program will begin at 2:00 p.m. A social hour will be followed by dinner at 6:00 p.m.

After-dinner speaker will be George H. Saville, Columbus, public relations director for the Ohio State Medical Association, who will discuss the subject, "You and Your Public."

The program is being planned by Dr. Harry Nenni, president, and Dr. George N. Spears, secretary, and other members of the local committee. Plans are being made for a program for Auxiliary members.

Dr. C. L. Pitcher, Portsmouth, Councilor of the Ninth District, will play a prominent role in the meeting.

All physicians of the area and their wives are invited to attend this meeting. A nominal charge will be made to cover cost of dinner.

* * *

Sixth District Postgraduate Day Youngstown, October 24

Plans for the Annual Sixth Councilor District Meeting to be held this year in Youngstown, have been announced, and all indications point to a

highly successful event. The meeting is scheduled for Wednesday, October 24, in the Stambaugh Auditorium.

Selection of the Auditorium for this year's meeting will provide much more adequate facilities for both members and exhibitors, including larger parking area, modern sound and visual equipment, with lunch available on the premises. The banquet will be held in the evening at the Pick-Ohio Hotel.

An interesting and unusual selection of speakers has been obtained to make for a stimulating and informative meeting. This will include a special panel of experts from Loyola University for the Section of Obstetrics and Gynecology.

The Woman's Auxiliary will hold their sixth district meeting at the same time, with a luncheon at the Mural Room for members. All wives who are not active members are cordially invited and urged to attend. Interesting entertainment, as well as a cocktail party for the ladies, will be provided to make it an enjoyable day for the wives.

Highlighting the banquet in the evening, for members and their wives will be the speaker, Dr. Douglas Bond, of Western Reserve University, who will give his own refreshing views on how a psychiatrist sees the practicing physician.

As is customary, there will be morning and afternoon sessions, followed by the banquet and after-dinner address.

The following subjects and speakers have been announced:

Recent Advances in Treatment of Leukemia and Lymphomas, Dr. Frank H. Bethel, professor of internal medicine, University of Michigan, Ann Arbor.

Dr. Robert J. Coffey, professor of surgery, Georgetown University School of Medicine, Washington, D. C.

Dr. Chester Gajewski, clinical instructor, Department of Obstetrics and Gynecology, Stritch School of Medicine of Loyola University, Chicago.

Newer Aspects of Virology, Dr. Eli Gold, Department of Pediatrics and Contagious Diseases, City Hospital, Cleveland.

Glomerulo Nephritis and Nephrosis, Dr. Malcolm Halliday, assistant professor in pediatrics, Children's Hospital, Pittsburgh, Pa.

Fluid Balance, Dr. William S. Hoffman, lecturer in medicine, University of Illinois College of Medicine, Chicago.

Dr. John Isaacs, clinical assistant, Department of Obstetrics and Gynecology, Stritch School of Medicine, Loyola University.

Inborn Errors of Metabolism, Dr. Robert Klein, associate professor in pediatrics, Children's Hospital, Pittsburgh, Pa.

Etiological and Embryological Approach to Therapy of Cryptorchidism, Dr. C. Everett Koop,

surgeon-in-chief, Children's Hospital, Philadelphia, Pa.

Cause, Treatment and Prophylaxis of Athletic Injuries, Dr. Aaron L. Lietman, professor of surgery, New York Polyclinic Hospital and Medical School, New York City.

Diagnosis and Treatment of Tumors of the Thyroid, Dr. Anthony V. Partipilo, associate clinical professor, University of Illinois, School of Medicine, Chicago.

Dr. Robert Priest, Department of Gastroenterology, Henry Ford Hospital, Detroit, Mich.

Dr. Herbert E. Schmitz, professor and chairman, Department of Obstetrics and Gynecology, Stritch School of Medicine of Loyola University, Chicago.

Chronic Pulmonary Emphysema, Dr. Maurice S. Segal, Clinical professor of medicine, Tufts School of Medicine, Boston, Mass.

Dr. Charles J. Smith, clinical professor, Department of Obstetrics and Gynecology, Stritch School of Medicine, Loyola University.

Common Endocrine Problems in Pediatrics, Dr. Samuel Spector, professor of pediatrics, Western Reserve University School of Medicine, Cleveland.

Hemorrhagic Disorders, Dr. Mario Stefanini, director of research, St. Elizabeth Hospital, Brighton, Mass.

Dr. Emmerich von Haam, professor of pathology, Ohio State University College of Medicine, Columbus.

The Psychiatrist Looks at His Fellow Physician, Dr. Douglas Bond, professor of psychiatry, Western Reserve University, Cleveland.

* * *

Rheumatic Diseases To Be Subject At Cleveland Clinic Program

The Frank E. Bunts Educational Institute of the Cleveland Clinic Foundation has announced a postgraduate continuation course, entitled "Progress in Management of Rheumatic Diseases," Wednesday and Thursday, October 24 and 25. The Institute is located at 2020 East 93rd Street, Cleveland.

Guest speakers will include the following physicians:

Dr. William S. Clark, Cleveland, assistant professor of medicine, Western Reserve University School of Medicine;

Dr. Salvatore R. LaTona, Niagara Falls, New York, assistant in medicine, University of Buffalo School of Medicine; and

Dr. William D. Robinson, Ann Arbor, Mich., professor of medicine, University of Michigan Medical School, and president of the American Rheumatism Association.

Other participants in the program are members of the Bunts Institute faculty.

Registration opens at 8:00 a. m. on October 24

with the program beginning at 9:00 a. m. on both mornings. A nominal registration fee will be required of registrants with the exception of interns, residents and members of the Armed Forces in uniform.

The program has been announced as follows:

WEDNESDAY MORNING SESSION

Dr. Arthur L. Scherbel, Department of Rheumatic Disease, presiding.

Introductory Remarks by Dr. Charles L. Leedham, director of education.

Dermatomyositis, Dr. George H. Curtis, Department of Dermatology.

Diagnosis and Treatment of Septic Intervertebral Disc, Dr. W. James Gardner, Department of Neurological Surgery.

Natural History of Rheumatoid Arthritis, Dr. Robinson.

Modern Concepts of Lupus Erythematosus, Dr. John R. Haserick, Department of Dermatology.

Histopathological and Clinical Manifestations of Angiitis, Dr. Sidney L. Schuchter, Department of Rheumatic Disease.

Pathologic Changes in Certain of the So-Called Collagen Diseases, Dr. John B. Hazard, Department of Pathology.

Symposium: Early Diagnosis of Collagen Disease, Dr. Scherbel, moderator; Drs. Curtis, Haserick, Hazard and Robinson.

WEDNESDAY AFTERNOON SESSION

Dr. Robinson, presiding.

Diagnostic Laboratory Procedures in Rheumatoid Arthritis, Dr. Clark.

Physical Therapy in Rheumatoid Arthritis, Dr. Paul A. Nelson, Department of Physical Medicine and Rehabilitation.

Chemotherapy in Rheumatoid Arthritis: A Concept, Dr. Scherbel.

Surgery in Advanced Joint Disease, Dr. Alfred W. Humphries, Department of Orthopedic Surgery and Vascular Surgery.

Diagnosis and Treatment of the Painful Shoulder, Dr. James I. Kendrick, Department of Orthopedic Surgery.

Tension Fibrositis, Dr. Leonard L. Lovshin, Department of General Medicine.

Clinical Manifestations of Pulmonary Hypertrophic Osteoarthropathy, Dr. Donald B. Effler, Department of Thoracic Surgery.

Symposium: Management of Rheumatoid Arthritis and Related Disorders, Dr. Scherbel, moderator; Drs. Haserick, Humphries, Nelson, Robinson, and Dr. Penn G. Skillern of the Department of Endocrinology.

THURSDAY MORNING SESSION

Dr. Scherbel, presiding.

Acute Rheumatic Fever, Dr. Robert D. Mercer, Department of Pediatrics.

Rheumatic Heart Disease, Richard N. Westcott, Department of Cardiovascular Disease.

(Continued on Page 1076)

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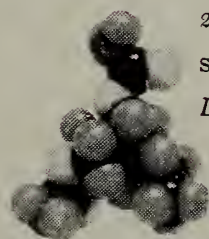
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The Carpal Tunnel Syndrome, Dr. George S. Phalen, Department of Orthopedic Surgery.

Management of Osteoarthritis, Dr. LaTona.
Presentation of Cases.

THURSDAY AFTERNOON

Tour of the Clinic and Hospital.

* * *

St. Luke's of Cleveland To Present Fall Postgraduate Symposium

Thursday and Friday, November 1 and 2, are the dates set for the fall postgraduate symposium of Saint Luke's Hospital on the subject, "Environmental Medicine—in Industry and the Home."

In contrast to the usual approach to environmental medicine—by classes of injurious agents—the St. Luke's program is designed to approach the problem from the customary relationship of the physician and patient, namely, as body systems that may be influenced by environmental agents, according to Dr. George W. Wright, general program chairman. It has been arranged to augment the presentation of each specialist with formal discussion by a physician in general practice or occupational medicine.

Unless otherwise stated, speakers are members of the staff of St. Luke's Hospital. Speakers have been chosen because they have day-to-day activity in their particular spheres, Dr. Wright stated.

Scientific sessions will be held in the Prentiss Auditorium of Saint Luke's Hospital, 11311 Shaker Blvd., Cleveland. Registration opens at 8:00 a. m. on November 1 with the program beginning at 9:00 a. m. on both mornings. Interns, residents and members of the Armed Forces in uniform will be admitted without charge. Otherwise there will be a registration fee of \$10.

The program is as follows:

THURSDAY MORNING, NOV. 1

Dr. Wright, presiding.

Welcome and opening remarks by Mr. Theodore Thoburn, president of St. Luke's Hospital Association, and Dr. Herbert W. Salter, representing the Ohio Academy of General Practice.

The Integument, Dr. Herbert Johnson.

The Eye and Conjunctiva, Dr. Russell J. Nichol.

Respiratory System, Raymond C. McKay, Cleveland City Hospital.

Disability in Pulmonary Injury, Dr. Wright.

THURSDAY AFTERNOON

Dr. Donald D. Brannon, presiding

The Heart, Dr. A. D. Nichol.

Peripheral Vascular System, Dr. F. A. Simeone, Cleveland City Hospital.

Types and Biological Effects of Radiation, Dr. H. F. Inderlied.

Health Aspects of the Use of Radiation in Industry, Dr. Charles L. Dunham, director, Division of Biology and Medicine, Atomic Energy Commission, Washington, D. C.

FRIDAY MORNING

Dr. Howard Hopwood, presiding.

Blood and Reticuloendothelial System, Dr. Charles S. Higley.

The Auditory Apparatus, Dr. Charles Kinney.

The Neuromuscular System, Dr. J. H. Nichols.
Allergy, Dr. William Garver.

FRIDAY AFTERNOON

Dr. Harold Theisen, presiding.

Acute Poisoning in Children, Dr. Richard Hodges.

Acute Poisoning in Adults, Dr. Lester Adelson, Cuyahoga County Coroner's Office.

Employment of Handicapped, Dr. Donald A. Kelly, chairman, Committee on Rehabilitation, Cleveland Academy of Medicine; Mr. William C. Hartman, partner, Cleveland law firm of Squire, Sanders and Dempsey, and Dr. Herman Hellerstein, director, Work Classification Clinic, Cleveland Area Heart Society.

Adjournment, 5 p. m.

* * *

Ohio Academy of General Practice Offers Seminar on Hypnosis

The Ohio Academy of General Practice has announced "A Seminar on Hypnosis" to be held at the Deshler-Hilton Hotel, Columbus, November 30 - December 2. Included in the seminar will be induction techniques, hypnotherapy and hypnodontia. Attendance is limited to physicians and dentists.

The faculty consists of the following persons: Milton H. Erickson, M. D., Phoenix, Ariz., diplomate of the American Board of Neurology and Psychiatry and Fellow of the American Psychiatric Association;

Edward E. Aston, D. D. S., West New York, New Jersey, member of the American Dental Association and the Chicago Society of Clinical Hypnosis and past-president of the American Hypnodontic Society;

Seymour Hershman, M. D., Chicago, member of the American Academy of General Practice, member of the Society of Clinical and Experimental Hypnosis and instructor at Marquette University Medical School;

William S. Kroger, M. D., associate professor of obstetrics and gynecology at Chicago Medical School, and president of the Chicago Society of Clinical Hypnosis; and

Irving Sector, D. D. S., member of the Society of Clinical and Experimental Hypnosis and in-

structor at the Chicago Academy of Dental Psychosomatics.

Additional information may be obtained from the office of the Ohio Academy of General Practice, 209 S. High Street, Columbus.

* * *

EENT Postgraduate Conference
Scheduled at Ohio State

Sponsored by the Ohio Academy of General Practice and the Departments of Ophthalmology and Otolaryngology, of the Ohio State University College of Medicine, a postgraduate conference on Ophthalmology and Otolaryngology will be held at the University, November 7-8.

The program will be held in the Ohio Union building on the campus, High Street at 13th Avenue. Twelve credit hours have been allowed for this course by the Ohio Academy of General Practice. Registration fee will be \$15. Additional information may be obtained from Dr. William Havener, Department of Ophthalmology, University Hospital, Columbus 10, Ohio.

The program has been announced as follows:

WEDNESDAY, NOVEMBER 7

Registration beginning at 8:00 a.m. with the program beginning at 9:00 a.m.

- Emergency Care of Eyes, Dr. James Andrew
- Diseases of the Lids, Dr. Martin Cook
- Corneal Lesions, Dr. George Stine
- Problems of Blindness, Dr. Claude Perry

WEDNESDAY AFTERNOON

- Recent Advances in Antibiotic Therapy (1:00 p.m.), Dr. Edward Carr
- Steroid Therapy in EENT, Dr. Carr

THURSDAY, NOVEMBER 8

- The Headache Problem (9:00 a.m.), Dr. Ray Hilsinger
- Management of Nasal Injuries, Dr. Hilsinger

THURSDAY AFTERNOON

- Fundus Changes of General Disease, Dr. William Havener
- Indications for Refraction, Dr. Jack Bontley
- Artificial Eyes, Mr. Joseph Bitonte
- Pediatric Ophthalmology, Dr. Morris Battles

American Public Health Association

Some 4,000 persons in various phases of public health work are expected to attend the 84th annual meeting of the American Public Health Association and meetings of 40 related organizations in the Atlantic City Convention Hall, November 12-16. Details may be obtained from the organization at 1790 Broadway, New York, New York.

By virtue of the high esteem in which his profession is held, the doctor is obligated to vote November 6.

Physicians Who Attended Annual Meeting
Represented Many Branches of
Practice, Study Shows

A break-down of attendance figures at the 1956 Annual Meeting in Cleveland reveal some interesting facts in regard to the wide variety of the various branches of practice represented at the meeting.

This comparison was made in the interest of the annual meeting program by comparing the attendance record with biographical cards in the OSMA Headquarters Office. The results substantiate the policy of the Committee on Scientific Work which has consistently slanted most of the annual meeting program features to appeal to physicians in all branches of practice.

Here is the break-down by specialty of the 1,601 members of the Association who attended the 1956 Annual Meeting in Cleveland last April:

Specialty	Cuyahoga County	Other Counties	Total
General Practice	194	489	683
Internal Medicine	84	59	143
Surgery	64	89	153
Obstetrics & Gynecology	47	39	86
Obstetrics	8	3	11
Gynecology	1	2	3
Pediatrics	27	48	75
Dermatology	13	6	19
Ophthalmology	35	23	58
O. A. L. R.	5	16	21
A. L. R.	9	7	16
Psychiatry	21	27	48
Psychiatry & Neurology ..	9	15	24
Neuro-Surgery	10	15	25
Thoracic Surgery	5	5	10
Industrial	7	7	14
Roentgenology, Radiology ..	15	13	28
Physical Medicine	10	2	12
Urology	22	22	44
Anesthesiology	15	18	33
Pulmonary	10	12	22
Cardiovascular	4	—	4
Allergy	4	3	7
Pathology	8	4	12
Public Health	6	11	17
Plastic Surgery	1	—	1
Orthopedic Surgery	6	8	14
Proctology	2	8	10
Resident	2	5	7
Hospital Administration ..	1	—	1
	645	956	1601

Medico-Legal Films

A series of films on medico-legal problems will be produced by the pharmaceutical firm of William S. Merrell Co. of Cincinnati in cooperation with the AMA's Law Department. The first film—dealing with the doctor as a medical expert witness—will be previewed at the AMA's Clinical Session in Seattle. This film will be available for showings at state and county medical society meetings after December 15.

AMA Clinical Session . . .

Excellent Program Being Planned in Seattle, Wash., November 27-30;
Physicians Who Plan To Attend Advised To Make Early Reservations

OHIO physicians will have the opportunity of combining a trip to the West Coast with attendance at an excellent medical program when the American Medical Association holds its Clinical Session in Seattle, November 27-30.

A complete program of activities will be printed in an early issue of *The Journal of the AMA*. Physicians are advised to make reservations early. Current issues of the *AMA Journal* are carrying hotel reservation forms which may be forwarded to the Housing Committee.

The Woman's Auxiliary will provide an excellent program and activities for the ladies.

Ohio will be represented in the House of Delegates by its official delegation.

Center of activities will be Seattle's Civic Auditorium, where scientific sessions will be held and exhibits will be displayed. Conveniently located, the auditorium is easily accessible from downtown hotels, and transportation will be available for commuting to and from the meetings. A cafeteria will be operated in the auditorium for midday meals.

Clinical Session headquarters will be the Olympic Hotel, where House of Delegates sessions and meetings of the Board of Trustees, councils and reference committees will be held.

A PRACTICAL PROGRAM

The scientific program will be beamed at the general practitioner, and subjects have been carefully chosen to be of interest and practical value. The program will include panel discussions, individual papers, motion pictures and closed-circuit television clinics.

The panel discussions will cover such subjects as hypertension, hemolytic anemia, prenatal care, problems of aging, epilepsy, low back pain, liver disease and vascular disorders. Twenty topics will be considered by panels of men prominent on the national scene and in the Northwest.

There will be 45 papers dealing with such subjects as fluid balance, urological problems, office psychiatry, varicose veins, fractures, diabetes and heart disease. Well-known medical educators and practicing physicians from all parts of the country will participate.

WET AND DRY CLINICS

The television clinics will include both wet and dry programs. There will be clinics on block anesthesia, treatment of burns, bleeding problems, intestinal obstruction, caesarean section, hand surgery, vein stripping and other subjects.

The program for the medical motion pictures and the schedule of papers, panels and television shows will be published soon in the *AMA Journal*.

Scientific and technical exhibits have been arranged through AMA headquarters. They promise to be as interesting and varied as in the past.

Prepaid medical service plans of Washington, Oregon and Idaho are planning to conduct a hospitality suite in grand style for three days during the session. The prepaid plans of these states also will present an exhibit of their services to the public.

Central Ohio Heart Association Announces List of Officers

Dr. Donald L. Mahanna, Columbus, was elected president of the Board of Trustees of the Central Ohio Heart Association at a recent meeting of the Board. Other officers elected were: Dr. R. W. Kissane, Columbus, chairman of the board; Dr. G. I. Nelson, Columbus, vice-president; John H. McCoy, Columbus; treasurer; Charles McCoy, Columbus, assistant treasurer; and Mrs. Doris Downey, Dover, secretary.

The other members of the Board are: Dr. H. M. Clodfelter, Columbus; Dr. Charles A. Doan, Columbus; Dr. Wiley Forman, Columbus; Mr. Merle D. Evans, Massillon; Dr. Harry Gauchat, Canton; Dr. Robert C. Kirk, Columbus; Dr. Louis A. Mitchell, Newark; Mr. Carl Mitcheltree, Columbus; Dr. M. H. Rosenblum, Steubenville; Senator John W. Bricker, Columbus; Mr. Robert O'Brien, Columbus; Mr. John Tingle, Cambridge; Mr. William Wieland, Springfield; Dr. Frank M. Wiseley, Findlay; Dr. Donald E. Yochem, Columbus; Dr. George Morrice, Jr., Columbus; and Dr. Perry R. Ayres, Columbus.

Dr. George Morrice, Jr., was elected president of the Scientific Council of the Central Ohio Heart Association at a recent meeting of the Council. Other officers of the Scientific Council elected were: Dr. M. H. Rosenblum, second vice-president; Dr. Harry Gauchat, first vice-president; and Dr. Perry Ayres, secretary.

The Scientific Council will conduct four medical meetings in Columbus and four in Central Ohio and supervise the research of the Association.

Your vote is your voice in government. Speak up election day—November 6!

KNOX

Protein Previews



New Study Shows Gelatine Restores Brittle Fingernails to Normal

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1. Rosenberg, S. and Oster, K. A., "Gelatine in the Treatment of Brittle Nails," *Conn. State Med. J.* 19:171-179, March 1955.
2. Tyson, T. L., *J. Invest. Dermat.* 14:323, May 1950.

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Party Platforms and Medicine . . .

What Are the Issues on Medicine and Health as Stated in the Party Platforms? Here Is a Summary. They Are All-Important to Doctors

WITH a general election only a matter of weeks away—November 6—members of the medical profession in Ohio, as well as members of associated professions, will find of particular interest planks in the state and national Republican and Democrat platforms related, directly or indirectly, to medicine.

For that purpose, the following consists of statements of policies and intentions taken from the platforms of the two parties.

OHIO REPUBLICAN PLATFORM

Following are excerpts of particular interest to Ohio physicians as taken from the State Republican platform:

On Agriculture: "Expansion of Ohio's strong programs at its colleges of agriculture, veterinary medicine and the agricultural experiment stations."

On juvenile delinquency: "We pledge ourselves to a program designed to reduce juvenile delinquency in Ohio and to rehabilitate youthful offenders in order that they may take their proper places in society."

On Workmen's Compensation: "We advocate the improvement and broadening of our rehabilitation, safety and accident prevention programs. We pledge to administer the workmen's compensation law so as to insure the prompt payment of compensation to injured workmen. We pledge to review the fairness of the rate structure of the Industrial Commission."

On public health, mental health and corrections: "We believe the care and treatment of the unfortunate citizens of this State who must call upon their government for aid is a responsibility of the State which must be promptly and efficiently administered, and is a responsibility which cannot be met by the granting of financial assistance alone."

"We believe the programs involving the aged, the blind, dependent children and the permanently disabled should be administered by using the same standards for all programs; by employing qualified personnel who can give adequate direction and supervision; and by providing health care, recreation and rehabilitation to permit the persons covered by these programs to live healthy, happy and productive lives."

"We pledge an administrative interdepartmental committee to organize the resources of our State government in solving the problems of Ohio's 750,000 senior citizens who are 65 or more years of age."

"We believe in a penal institution program which emphasizes rehabilitation and training so that offenders against society may be salvaged for a useful life. Youthful offenders must be protected from the corruptive effects of association with hardened criminals."

On natural resources: "We believe pollution, waste of water and erosion to be major problems. We will accelerate programs designed to encourage efficient use and conservation of our water supply and to protect our streams and shorelines."

OHIO DEMOCRATIC PLATFORM

Planks in the Democratic Party of Ohio platform of particular interest to Ohio physicians include the following statements:

On agriculture: "The Ohio Food and Drug Act should be modernized to meet the requirements of modern food technology and progress in order to cope with widespread misuse of drugs as sedatives and stimulants."

On conservation and natural resources: "We urge effort to eliminate pollution in our lakes, rivers, and air. This is imperative to protect the health of the fast-growing population of our cities and villages. We should assist our hard-pressed municipalities in solving this difficult problem."

On health: "The health of our people is of extreme importance to our society and economy. It must be maintained not alone through medical services, but also through research methods to improve our food and living conditions generally. The Ohio Department of Health is to be commended for its increased activities, including the surveillance of stream pollution, investigation of communicable diseases, its efforts to overcome the shortage of nurses, its program of public health education and establishment of local general hospitals."

"This program for the establishment of local general hospitals must be continued. We favor the continuation and extension of existing programs for the treatment and rehabilitation of alcoholics."

"The State of Ohio must also recognize the great social and economic problem of narcotic addiction."

"Increased vigilance and expanded cooperation in the use of federal facilities must be utilized to stamp out this evil."

"Legislation pertaining to those who have suf-

ferred from epilepsy should be reviewed to the end that they should be afforded just consideration as citizens of our state."

On Workmen's Compensation: "We favor a study of the establishment of conciliation services and a labor relations board, either as a separate department or as a branch of the Industrial Commission.

"The amendments to the Workmen's Compensation Act sponsored by labor organizations has expedited payments and cut down delays. A more workable and understandable appeal procedure should be adopted. We are pledged to increase benefits for injured workmen, and legislation to remove any existing injustices or discriminations. We are opposed to any weakening of the basic Workmen's Compensation Law.

On local governments: "Urban redevelopment and slum clearance must be fostered not only by appropriate legislation but by cooperation with local governments. We urge the review of legislation necessary to encourage joint and cooperative action by adjoining governmental units.

On mental hygiene: "We commend the voters of Ohio for the adoption of a constitutional amendment to provide much needed facilities for the care and treatment of the mentally ill. While facilities are being expanded, and additional psychiatrists, therapists and skilled attendants employed, we favor the continuation and expansion of this program.

"We believe state aid must be continued for the education and care of mentally retarded children with the view not only of receiving proper care but also to have them achieve appropriate education to establish themselves in community life."

On old age benefits: "We pledge to give full recognition to the rights and needs of our older citizens, and thus encourage them in leading proud and independent lives throughout the span of their years. Present payments should be reconsidered and evaluated in connection with the increased cost of living. We will remove the statutory ceiling on old age pensions and give the Welfare Department director the authority to establish budgets on the basis of individual needs. We will appropriate sufficient monies to pay for the medical and hospital care of old age pensioners.

"We commend the Democratic Congress over presidential opposition for the enactment of amendments to Social Security legislation whereby women may retire and receive benefits at the age of 62, and the permanently disabled at 50."

On public welfare: "The state has a responsibility to aid the aged, the blind, the disabled, the dependent child, the crippled child, the widowed mother, and the poor. Available ap-

propriations for the care of these unfortunate will be of foremost consideration."

NATIONAL PARTY PLANKS

Following in abbreviated form are the health and welfare planks in the national platforms of the two parties:

DEMOCRATIC

On Social Security: Takes party credit for lowering retirement age for women and disabled, and pledges "increasing benefits to keep pace with improving standards of living; by raising the wage base upon which benefits depend, and by increasing benefits for each year of coverage."

On health and medical care: Pledges initiation of programs of Federal financial aid, "without Federal controls," for medical education, more support of hospital construction and increased Federal aid to public health services, "particularly in rural areas."

On medical research: Promises support of "all efforts, both public and private, to wage relentless war on diseases which afflict the bodies and minds of men."

On physically handicapped: Pledges "vastly expanded" rehabilitation program for physically handicapped, including increased aid to states.

REPUBLICAN

On Social Security: Pledges extension "and perfection of a sound Social Security system."

On Federal aid to medical schools: Demands, "despite reluctance of Democrat 84th Congress," federal assistance to help build facilities to train more physicians and scientists.

On health reinsurance: Urges reinsurance and pooling arrangements to expand and improve voluntary health insurance.

On radio-isotopes for medicine: Pledges continued use of radio-active isotopes in clinics, hospitals, industry and on farms.

Illegal Use of Narcotics in Ohio Reported Cut in Half

Ohio dope traffic has been reduced by half or more since a new Ohio law against narcotics went into effect 13 months ago, according to a Federal Narcotics Bureau spokesman.

The spokesman, Narcotics Agent Al Cook, Columbus, believes illegal use of narcotics in the state is "at a minimum," thanks to the new and tougher law.

He said Ohio has "the best anti-dope law in the country," that penalties are more severe than under the new Federal law, with the exception of the provision in the Federal law calling for capital punishment of peddlers who sell narcotics to minors.

Reply to Stover Report . . .

Joint Commission Considers Resolution Submitted to It by the AMA and Responds with Statement; Other Matters also Considered

A FURTHER step toward agreement between the procedure of the Joint Commission on Accreditation of Hospitals and recommendations of the House of Delegates of the American Medical Association was taken when the Board of Commissioners of the Joint Commission met July 28.

The board of the Joint Commission considered step by step the Stover Report, and issued a statement based on its considerations. The Stover Report, known officially as the "Report of the Committee To Review the Functions of the Joint Commission on Accreditation of Hospitals," was approved by the House of Delegates of the AMA in June. Dr. Wendell C. Stover, a delegate from Indiana, was chairman of the committee created by the House of Delegates in 1955. (Refer to August issue of *The Journal*, page 870.)

Following are the 17 points of the summary conclusions of the Stover Report, printed in *Italic type*, followed in each case by comments of the Joint Commission, printed in Roman type:

1. *Accreditation of hospitals should be continued.*

1. Agreement.

2. *The Joint Commission should maintain its present organizational representation.*

2. Agreement.

3. *The Board of Trustees should report annually to the House of Delegates on the activities of the Joint Commission.*

3. No action by the Board of Commissioners indicated.

4. *Physicians should be on the administrative bodies of hospitals.*

4. Very close liaison between the medical staff and the governing board of a hospital must be maintained. The method used to accomplish this should be determined locally.

By way of explanation, the Commissioners think that the composition of the governing board of a hospital should be determined at the local level and that the Commission should not specifically state whether physicians should or should not be members. From its inception, the Commission through its publications has stated that in accredited hospitals close liaison between the medical staff and the governing board is essential. To assure good quality patient care, good working relationships are vital. However, the selection of the most effective way to accomplish this goal in the individual hospital can best be determined locally.

We call your attention to the recommendations made in June 1953, by the Joint Committee of the Boards of Trustees of the American Medical Association and the American Hospital Association on Hospital-Physician Relationships. We quote as follows—

"The general purpose of hospitals and physicians is to aid each other in the delivery of the best possible medical care to patients. To attain such a purpose requires full cooperation among medical staffs, governing boards and administrative heads of hospitals. One important method of attaining this objective is that duly designated representatives of the medical staff shall have full and direct access to the governing board with due consideration to the position of the administrator as chief executive officer of the hospital. The various methods by which the medical staff may have access to the hospital governing board follow. These methods are not listed in the order of their desirability, and there may be other acceptable liaison plans developed depending upon local conditions.

"a. The executive committee of the medical staff and a committee of the governing board with the hospital administrator can serve as a joint committee.

"b. Representatives of the medical staff can serve as members of the medical staff committee of the governing board with the hospital administrator.

"c. Representatives elected by the medical staff can attend meetings of the hospital governing board.

"d. Members of the medical staff can be members of the hospital governing board."

To repeat, the Standards for Hospital Accreditation state that the "governing body . . . should . . . establish a formal means of liaison with the medical staff preferably by a joint conference committee" (a or b above); however any one or combination of the above methods that prove effective are acceptable.

5. *General practice sections in hospitals should be encouraged.*

5. The present policy of the Commission with respect to general practice sections should be continued, that the decision as to the establishment of a general practice department should be made by the local medical staff.

6. *Staff meetings required by the Joint Commission are acceptable, but attendance require-*

ments should be set up locally and not by the Commission.

6. Referred to a committee for study; a report and recommendations to be submitted at the next meeting of the Board of Commissioners to be held in December, 1956.

Since this Conclusion constitutes a change in the Standards, the established procedure for changing standards was followed. In April, 1954, the Commissioners voted that the following procedure for changing the Standards for Hospital Accreditation be adopted:

"Any proposal for a change, addition or deletion in the Standards for Hospital Accreditation of the Joint Commission on Accreditation of Hospitals shall be presented and discussed at a regular meeting of the Board of Commissioners. A committee shall then be appointed to submit recommendations at the next regular meeting of the Board of Commissioners. If agreement to the proposed change is unanimous among those present and voting, the proposal will be adopted. If there is one or more dissenting votes, action will be deferred until the next meeting of the Board, at which time a majority vote will be decisive."

7. *The Joint Commission should not concern itself with the number of hospital staffs to which a physician may belong.*

7. The Standards for Hospital Accreditation do not restrict multiple staff appointments.

8. *The Joint Commission is not and should not be punitive.*

8. Agreement.

9. *The Joint Commission should publicize the method of appeal to hospitals that fail to receive accreditation.*

9. In the event a hospital is not accredited following a survey, the process of appeal will be explained in the letter notifying the hospital that it has not been accredited.

The original Bylaws of the Joint Commission on Accreditation of Hospitals in Article III, Section 8 provide for such hearings. A copy of the Bylaws was distributed with the first issue of the Bulletin of the Commission in November, 1952.

10. *Reports on surveys should be sent to both administrator and chief of staff of hospitals.*

10. Copies of the covering letter and recommendations sent to the administrator following a survey will also be sent to the chief or president of the medical staff and the president of the governing board.

11. *Surveyors should be directly employed and supervised by the Joint Commission.*

11. There is no objection in principle that surveyors could be directly employed and supervised by the Commission.

Whether or not this is done is a decision for

each member organization of the Commission to make.

12. *Surveyors should work with both administrator and staff.*

12. Agreement.

13. *New surveyors should receive better indoctrination.*

13. The orientation program for surveyors is being steadily strengthened.

14. *Blue Cross and other associations should be requested not to suspend full benefits to non-accredited hospitals until those so requesting have been inspected.*

14. Pertains to individual Blue Cross Plans and cannot be acted upon by the Joint Commission on Accreditation of Hospitals.

15. *The American Medical Association should conduct an educational campaign for doctors relative to the functions and operations of the Joint Commission.*

15. No action.

16. *The Committee also suggests that the American Medical Association and the American Hospital Association encourage educational meetings for hospital boards of trustees and administrators either on a state or national level to acquaint these bodies with the functions of accreditation.*

16. No action.

Although it is inappropriate for the Commission to take action on Conclusions 15 and 16, the Commission will actively support the member organizations in accomplishing these objectives.

17. *This Committee asks to be discharged upon submission of this report to the House of Delegates.*

17. No action.

OTHER ACTIONS OF THE JOINT COMMISSION

Following is additional information contained in the report of the Joint Commission as to policy:

In publishing the annual list of accredited hospitals, the practice has been to separate the fully accredited and provisionally accredited hospitals. These designations have been used for many years and the attitude has developed that provisional accreditation implies a secondary type of accreditation. This attitude is incorrect. The Commission has interpreted provisional accreditation to mean that a hospital meets the Standards for Accreditation to a degree that recognition should be given and that the potentialities for full accreditation exist. To avoid perpetuating a misunderstanding, hospitals will now be accredited for one year or for three years. In the annual published list no distinction will be made between hospitals accredited for three years and those accredited for one year.

Except for the publication of the annual list, there are no other changes in policy or admin-

istrative procedure. Accreditation for three years applies to those hospitals now fully accredited and accreditation for one year applies to those now provisionally accredited. Following a survey, the hospital will be informed of the period of time for which it is accredited. Those accredited for one year will be visited the following year. If on the second successive survey the hospital is again accredited for one year, it will be notified that following the third survey it must have improved patient care to warrant three year accreditation or be reduced to non-accreditation.

Certificates of Accreditation will be issued only to those hospitals accredited for three years.

ACCREDITATION OF PSYCHIATRIC HOSPITALS

The Board of Commissioners considered the program of accreditation of psychiatric hospitals. Daniel Blain, M. D., Medical Director, American Psychiatric Association, and Raymond W. Waggoner, M. D., Member, Central Inspection Board of the American Psychiatric Association, were invited to participate in the discussion. It was decided that a committee of the Board of Commissioners would request a meeting with representatives of the American Psychiatric Association to discuss the program further and submit a report at the next meeting of the Board of Commissioners.

Physicians and Hospitals Alerted on Outbreaks of Infections in Several Nurseries

Outbreaks of staphylococcal infection among newborns during recent weeks have prompted the Ohio Department of Health to issue warning memoranda to all Health Commissioners and hospital administrators throughout the state.

Dr. Ralph E. Dwork, Ohio director of health, stated in the memoranda that in each case the outbreak was of serious proportion "and included, in addition to the usual pustular dermatitis in the babies, breast abscesses in the mothers, other deep subcutaneous abscesses, and staphylococcal pneumonia complicated by pneumothorax and empyema in the babies."

He said that while there undoubtedly are several strains of pathogenic staphylococci capable of causing such outbreaks, those recently found in Ohio revealed a single strain in each instance. The organism is resistant to penicillin, streptomycin and aureomycin but is sensitive to bacitracin, chloramphenicol, erythromycin and albamycin. The phage type of the organism is 42B/44A/47C/52/81.

Pointing out that the laboratory plays an important role in the control of the infection, Dr. Dwork said the Department of Health's research laboratory is prepared to make complete identification, including bacteriophage typing. He

said the service is available to all Ohio hospitals upon request.

He added that the potential seriousness of the infections demands immediate cognizance of the situation, investigation and control.

"Perhaps the most important aspect of the problem is transmission of staphylococci from babies to staff members and the subsequent establishment of a reservoir of nasopharyngeal infection in the hospital personnel."

He said that once the reservoir is established, the usual method of dealing with nursery outbreaks makes little impression upon the course of the infection.

The Department's approach to the problem has been to place all newborn babies in an infected nursery on antibiotic prophylaxis for four or five weeks during which period repeated attempts are made to find the infected staff members and place them under antibiotic therapy, he said.

The department has asked health commissioners to bring to its attention the following conditions:

1. The appearance of pustular dermatitis, "infected heat rash," impetigo, or pemphigus neonatorum in any nursery.
2. The occurrence of staphylococcal pneumonia in children under six months of age.
3. An increased incidence of postpartum breast abscess.
4. An increased incidence of pustular dermatitis, furuncles, carbuncles or subcutaneous abscess in the members of families in which there is an infant under six months of age.

Dr. Dwork further stated, "The appearance of any or all of these manifestations strongly suggests the presence of staphylococcal infection in a newborn nursery."

County Medical Societies Civil Defense Conference

The annual conference of the County Medical Societies Civil Defense Organization is scheduled for the week-end of November 10-11. It will be held at the Morrison Hotel in Chicago, Illinois. A practical and informational program, including workshop sessions, is being arranged.

Individuals planning to attend this conference may obtain hotel accommodations by writing directly to the Morrison Hotel, since arrangements have been made to reserve a block of rooms for the conferees. Those requesting reservations should indicate they plan to attend the County Medical Societies Civil Defense Conference.

The word "idiot" is derived from classical Greek, "idiotes," meaning "those citizens who did not take part in public voting." Don't be an idiot November 6.

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OBJECTIVE AND SUBJECTIVE RESPONSE —Orally effective, Nilevar therapy is characterized by retention of nitrogen, potassium, phosphorus and other electrolytes in ratios indicative of protein anabolism. Moreover, subjectively the patient observes an increase in appetite and sense of well-being.

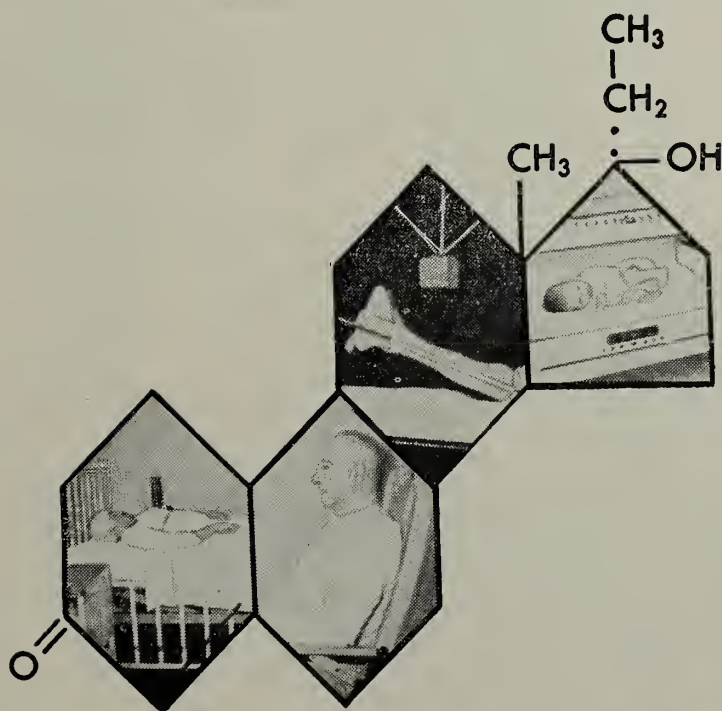
WELL TOLERATED —Nilevar has an extremely low toxicity. Laboratory animals fail to show toxic effects after six months of continuous administration of high dosages. Nilevar should not be administered to patients with prostatic carcinoma. Nausea or edema may be encountered infrequently. Slight androgenicity may be evidenced on high dosage or in particularly responsive individuals.

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DOSAGE—The daily *adult* dose is three to five Nilevar tablets (30 to 50 mg.) but up to 100 mg. may be administered. For *children* the average daily dose is 1 to 1.5 mg. per kilogram of body weight; individual dosages depend on need and response to therapy.

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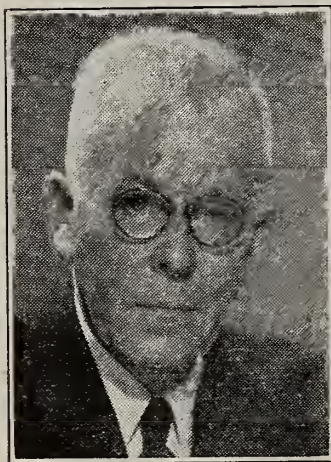
A Boost for Medical Schools . . .

Local Chairmen Are Named as Ohio Prepares for All-Out Campaign Among Doctors in Behalf of the American Medical Education Fund

OHIO PHYSICIANS again will have an opportunity this Fall to support the Nation's medical schools by contributing to the 1956 campaign of the American Medical Education Foundation.

Dr. Merrill D. Prugh, Dayton, is chairman of the Ohio AMEF Campaign Committee, which is composed of the 11 District Councilors of the Ohio State Medical Association. Each county medical society has a local chairman.

In 1951 two non-profit organizations were formed to attack the financial plight of medical schools through private support. The American Medical Education Foundation was established and sponsored by the American Medical Association to raise funds from the medical profession. The National Fund for Medical Education was organized to seek support for the medical schools from business and industry.



M. D. PRUGH, M. D.

Each year since 1951 money raised by the volunteer committees working for these two organizations, has been pooled and distributed in the form of unrestricted grants to the medical schools. In this way \$9,598,491.00 has been given to the Nation's 81 medical schools, and of this amount \$4,684,312.00 has come from the physicians of the country through the American Medical Education Foundation.

During the year 1955, a total of 25,116 contributors gave \$757,163.29 to AMEF. Contributions from 36,162 physicians directly to the Alumni Funds of their own schools amounted to \$1,748,587.46, making a grand total of \$2,505,750.75 contributed by physicians to the cause of medical education during the year.

In 1955, there were 2,963 gifts from Ohio for medical education, 649 through AMEF, and 2,314 to medical schools through Alumni organizations. The AMEF total for Ohio amounted to \$30,192.50, approximately \$5,000 more than in 1954. The total includes \$8,436.87 raised by the Woman's Auxiliary to the Ohio State Medical Association, considerably more than the Auxiliary's gift of \$4,855.00 in 1954. Gifts from medical alumni

located in Ohio directly to their own schools amounted to \$92,472.65 in 1955.

OHIO ONE OF "TOP TEN"

In publishing its annual report for 1955, the American Medical Education Foundation lists Ohio among "The Ten Top States," sixth in the amount of contributions and seventh in the number of contributors. The Board of Directors of the Foundation designated a number of organizations and individuals as recipients of the Award of Merit for "Outstanding gifts of time or money to the Foundation." Included are the following from Ohio: Woman's Auxiliary to the Cincinnati Academy of Medicine; Fred Douglass Foundation, Toledo; Medical Service Foundation of Mahoning County, Youngstown; Dr. Ralph W. Lewis, Portsmouth, and Dr. Simon A. Schlueter, Akron.

Under the energetic direction of the late Dr. William M. Skipp, Youngstown, who was Ohio AMEF chairman for four years, there was a steady increase in the number of Ohio physicians contributing and in the amount of their gifts for medical education. It is the sincere hope of Dr. Prugh and the members of the Ohio AMEF Committee that the approximately 3,000 Ohio physicians who contributed last year either through AMEF or directly to their own schools, will continue to do so—and also that more of their colleagues will realize the importance of keeping the Nation's medical schools financially solvent and independent, under private auspices.

The initial appeal for contributions will be in a letter mailed to each member of the Ohio State Medical Association. This will be followed up locally through solicitations by the county chairmen.

Following is a list of the county chairmen for the 1956 Ohio AMEF campaign:

FIRST DISTRICT

ADAMS—Herman P. Hyder, Bentonville
BROWN—Charles H. Maly, Sardinia
BUTLER—Elmer G. Sternberg, Hamilton
CLERMONT—John M. Coleman, Loveland
CLINTON—H. Richard Bath, Wilmington
HAMILTON—Stanley W. Whitehouse, Cincinnati
HIGHLAND—John G. Anderson, Lynchburg
WARREN—John E. Sharts, Franklin

SECOND DISTRICT

CHAMPAIGN—Arthur B. Ream, Mechanicsburg
CLARK—Lillian Posch, Springfield
DARKE—Gilbert E. Sayle, Greenville
GREENE—Harvey B. McClellan, Xenia
MIAMI—Frank J. Schrader, Troy
MONTGOMERY—Harold M. James, Dayton
PREBLE—A. L. Ross, Jr., West Alexandria
SHELBY—John H. Kerrigan, Sidney

(Continued on Page 1087)

THIRD DISTRICT

ALLEN—William V. Parent, Lima
 AUGLAIZE—David W. Nielsen, Waynesfield
 CRAWFORD—James E. Loggins, Galion
 HANCOCK—Henry P. Koehler, Findlay
 HARDIN—John A. Kramer, Ada
 LOGAN—Hobart L. Mikesell, West Liberty
 MARION—Philip W. Smith, Marion
 MERCER—Paul E. Beare, Celina
 SENECA—Avery D. Powell, Tiffin
 VAN WERT—S. A. Edwards, Van Wert
 WYANDOT—S. R. Bame, Carey

FOURTH DISTRICT

DEFIANCE—Richard A. Cunningham, Defiance
 FULTON—Clarence F. Murbach, Archbold
 HENRY—Richard L. Gilson, Napoleon
 LUCAS—Frank C. Clifford, Toledo
 OTTAWA—Cyrus R. Wood, Port Clinton
 PAULDING—Julian Movchan, Oakwood
 PUTNAM—Walter W. Donahue, Leipsic
 SANDUSKY—Frederick E. Mitchell, Bellevue
 WILLIAMS—Harvey F. Doe, Edgerton
 WOOD—H. W. Dierksheide, Pemberville

FIFTH DISTRICT

ASHTABULA—Carl J. Streicher, Ashtabula
 CUYAHOGA—Clifford J. Vogt, Cleveland
 GEauga—S. Hayashi, Chesterland
 LAKE—Richard W. McBurney, Painesville

SIXTH DISTRICT

COLUMBIANA—Robert N. Osmundsen, Salem
 MAHONING—Harry A. Smith, Youngstown
 PORTAGE—Robert M. Dumm, Kent
 STARK—J. F. Toot, Canton
 SUMMIT—Edwin W. Cauffield, Akron
 TRUMBULL—George Mokris, Warren

SEVENTH DISTRICT

BELMONT—Robert A. Porterfield, St. Clairsville
 CARROLL—Samuel L. Weir, Minerva
 COSHOCTON—Gerald A. Foster, Coshocton
 HARRISON—James Z. Scott, Scio

JEFFERSON—John L. Quinn, Steubenville
 MONROE—A. R. Burkhart, Woodsfield
 TUSCARAWAS—Samuel H. Winston, Dover

EIGHTH DISTRICT

ATHENS—Robert E. Main, Athens
 FAIRFIELD—Charles H. Hamilton, Lancaster
 GUERNSEY—William W. Bryant, Senecaville
 LICKING—Warren N. Koontz, Newark
 MORGAN—A. A. Coulson, McConnelsville
 MUSKINGUM—William B. Smith, Zanesville
 NOBLE—Edward G. Ditch, Caldwell
 PERRY—Charles E. Bope, Somerset
 WASHINGTON—W. D. Turner, Marietta

NINTH DISTRICT

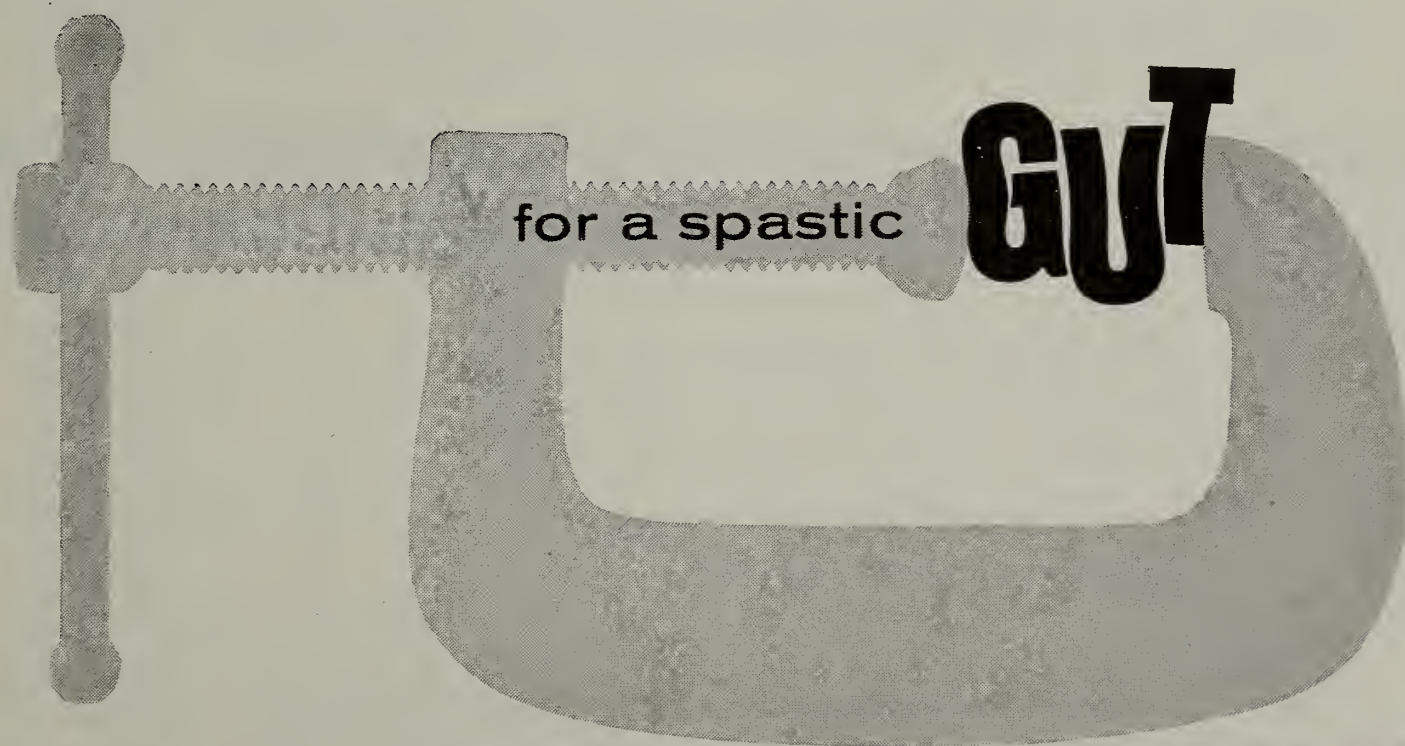
GALLIA—Oscar W. Clarke, Gallipolis
 HOCKING—Owen F. Yaw, Logan
 JACKSON—Tom Washam, Jackson
 LAWRENCE—John A. Dole, Jr., Ironton
 MEIGS—Charles J. Mullen, Pomeroy
 PIKE—Cecil L. Grumbles, Waverly
 SCIOTO—Marie B. Rogowski, Portsmouth
 VINTON—Herbert D. Chamberlain, McArthur

TENTH DISTRICT

DELAWARE—James G. Parker, Delaware
 FAYETTE—Jack H. Persinger, Washington C. H.
 FRANKLIN—George J. Hamwi, Columbus
 KNOX—Robert H. Hoecker, Mt. Vernon
 MADISON—Sol Maggied, West Jefferson
 MORROW—Stanley L. Brody, Cardington
 PICKAWAY—L. C. Schiff, Ashville
 ROSS—David McKell, Chillicothe
 UNION—James W. Sampsel, Marysville

ELEVENTH DISTRICT

ASHLAND—John M. Strait, Ashland
 ERIE—Dean E. Sheldon, Sandusky
 HOLMES—Neven P. Stauffer, Millersburg
 HURON—George F. Linn, Norwalk
 LORAIN—James S. Hawthorne, Lorain
 MEDINA—Arthur F. Wolf, Seville
 RICHLAND—Robert L. Garber, Mansfield
 WAYNE—F. C. Ganyard, Wooster



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Licenses Granted . . .

State Medical Board Issues Certificates to 392 Graduates of Medical Schools To Practice in This State Following the Summer Examinations

THE State Medical Board has issued certificates to 392 graduates of medical schools to practice medicine and surgery in Ohio, as a result of the examinations given in Columbus June 14-16. The list of those who passed the examinations was issued by Dr. H. M. Platter, Secretary, following a meeting of the Board on August 28.

Certificates to practice osteopathic medicine and surgery were issued to 41 graduates of osteopathic schools. In the limited practice branches the following numbers of persons were licensed: 8 in chiropody, 1 in mechanotherapy, 6 in chiropractic, 7 in massage and 3 in cosmetic therapy.

High grades in the examinations for doctors of medicine were made by the following persons: Thomas N. Gynn, Lakewood, Loyola University, 92.7 per cent; James M. Carhart, Youngstown, Northwestern University, 91.5; Atis K. Freimanis, Columbus, University of Hamburg, Germany, 90.8; Michael C. Galose, Jr., Youngstown, Ohio State University, 90.5; Ralph C. Tierney, Norwood, University of Cincinnati, 90.5; Erwin R. Zeller, Columbus, Ohio State University, 90.4; Albert H. Silverberg, Toronto, Canada, University of Toronto, 90.4; George A. Leighton, Jr., Toledo, Ohio State University, 90.2.

Following is the list of persons licensed to practice medicine and surgery. (In cases where the present residence and home town is different, the home town is given in parentheses.)

OHIO STATE UNIVERSITY—John W. Axline, Columbus; Ronald M. Backus, Dayton; Marvin L. Bellin, East Cleveland; Carhan E. Bloedow, Chicago, Ill. (Middletown); Robert F. Blythe, Ann Arbor, Mich. (Cincinnati);

David E. Boswell, Columbus (Franklin); Bernard Boxerbaum, Cleveland; Frederick M. Bram, Cleveland; Everett P. Bratcher, Galion; George E. Bruggemann, Columbus (Fostoria); Gail Warren Burrier, Worthington (Dayton);

Charles O. Chrysler, Columbus (Gahanna); Carson P. Cochran, Columbus (Napoleon); Manfred L. Cohen, Columbus (Dayton); Clyde W. Conger, Delaware; James M. Coulter, Columbus (University Heights, Cleveland); Glenn B. Crawford, Columbus (Euclid); Nicholas Csonka, Jr., Elyria;

John Thomas Dayton, Columbus (Marysville); Donald B. Dean, Wooster; Joseph E. DeMarco, Cleveland; Margaret Peoples Dishon, Lima (Cleveland); Neil H. Dishon, Lima (Findlay); Harold R. Dowell, Springfield (Canton);

William D. Eggleston, Columbus (Mansfield); Frederick W. Elder, Jr., Shaker Heights; John T. Evans, Jr., Akron; Robert S. Fladen, Steubenville; Hugh M. Frazer, Cincinnati; Ernest H. Friedman, Cleveland; William Ernest Furst, Columbus;

Michael C. Galose, Jr., Youngstown; Richard F. Gehring, Toledo; George W. Getz, Springfield; David B. Gilbert, Phoenix, Ariz. (Columbus); Jack L. Goldberg, Columbus; James S. Goldrich, Cleveland Heights; Jack M. Grant, Columbus (Steubenville); Robert W. Greene, Columbus;

James D. Hays, Kent; James H. Heckaman, Alliance (North Canton); Jo Ann Mary Hein, Pasadena, Calif. (Toledo); Hobart R. Helman, Columbus (Waverly); Wade Schoonover Helwig, Niles; Carl A. Henderson, Columbus (Portsmouth); Irwin A. Herman, Cleveland; James D. Hites, Columbus;

James B. Jackson, Columbus (New Philadelphia); Herbert G. Jakob, Cleveland Heights; William A. Jones, Columbus (Chillicothe); Ronald E. Kandel, Columbus; Burton A. Kassel, Columbus (Cleveland); John H. Kathe, Columbus (Elyria); James B. Katz, Shaker Heights; Robert P. Kaufman, Columbus (Troy); David M. Kawasaki, Columbus (Vermilion);

Robert L. Keener, Columbus (Ashland); Donald J. Kellon, Columbus (Cleveland); Milton D. Klein, Shaker Heights; Thomas G. Klever, Bowling Green; Max Louis Kochheise, Jr., Columbus; Wallace M. Korbin, Akron; Frank M. Kousaie, Canton;

James C. Kraner, Columbus (Pickerington); Leonard Kritzer, Shaker Heights; Austin H. Kuster, Canton;

Frank T. Lansden, Columbus (Akron); George A. Leighton, Jr., Toledo; George W. Loesch, Akron (Mansfield); Kenneth R. Lovell, Cleveland;

Roy Chihiro Machida, Columbus (Cleveland); Herbert A. Mahler, Barberton; Harold E. Manhart, Columbus (Bowling Green); James A. Martin, Flint, Mich. (Columbus); James F. Mason, Columbus (Wadsworth); Dean F. Massie, Columbus (Ironton); Philip V. Matlock, Columbus;

W. Duane McCarty, Columbus (Alliance); Thaddeus D. McGuire, Lima (Warren); Robert H. Merz, Akron (Cleveland); David G. Miller, Hicksville; Don E. Miller, Columbus (Spencerville);

John A. Mitchell, Jr., Columbus; Douglas P. Mooney, Columbus (Toledo); C. Roger Moritz, Columbus; William H. Moshier, Columbus (Mont-

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Dudley H. Page, Dayton (Cleveland Hts.); Glenn W. Patterson, North Olmsted; Alva B. Payne, Columbus (Ironton); Tom H. Pratt, Columbus; Steven A. Pollis, DeGraff (Columbus); Charles E. Pratt, Toledo; Walter F. Pretorius, Jr., Akron (Dover); Andrew J. Pultz, Columbus; James G. Punches, Sylvania;

Stephen V. Rader, West Jefferson; William A. Reynolds, Columbus (Xenia); R. Daniel Rigal, Liberty Center; John D. Royer, Fostoria; James L. Rush, Columbus (Metamore); James S. Russell, Columbus (Pomeroy);

Wm. T. C. Sawyer, Akron; William E. Schamadan, Dayton (West Richfield); Edward V. Schlicht, Sandusky (Bellevue); Clyde D. Schoenfeld, Youngstown; William J. Schulte, Toledo; Henry P. Sengelmann, Columbus;

Robert B. Shanck, Los Angeles, Calif. (Columbus); Richard A. Shurmer, Jr., Columbus (Cleveland); John B. Siddall, Oberlin; David Silver, Youngstown (Canton); Gordon F. Smith, Dayton (South Euclid); Donald W. Sobel, Youngstown; Konstantine K. Solacoff, Springfield; Charles C. Spencer, Columbus (Parma Heights);

Edwin L. Stanley, Jr., Miamisburg; Henry G. Stein, Columbus (Barberton); John D. Stephan, Oberlin; Robert J. Stern, East Cleveland; Sidney J. Stone, Jr., Cleveland; Jack Strom, South Euclid; Joseph Sudimack, Jr., Philadelphia, Pa. (Warren);

Lester W. Tarr, Akron; J. Daniel Timmons, Dayton (New Madison); Virgil Tirminia, Canton; Kenneth C. Tufts, Jr., Columbus;

Don G. Warren, Columbus (Newcomerstown); John D. Welsh, Dayton (Cleveland); Mary Lois Whitacre, Columbus (Chesterhill); Whitney R. White, Cleveland; Homer E. Williams, Columbus; James R. Wilson, Flint, Mich. (Dayton); David M. Winters, Columbus (Toledo)

Paul G. H. Wolber, Columbus; Robert C. Wymen, Columbus (Youngstown); Mary Florence Young, Chicago, Ill. (Columbus); Erwin R. Zeller, Columbus.

UNIVERSITY OF CINCINNATI—Don D. Aichholz, Cincinnati; John J. Anderson, Poland, Ohio; William Carl Ashman, Richmond, Va. (Ft. Wayne, Indiana);

Jack Barsman, Chicago, Ill. (Cincinnati); Ralph E. Bauer, Detroit, Mich. (Portsmouth); Harold Blumberg, Cincinnati; Frederick B. Brown, Batavia, (Billing, Mo.); Tom H. Brunsman, Cincinnati; Robert E. Burky, Alliance; Philip B. Burton, Cincinnati (Dayton);

James R. Carr, Hamilton; Mark G. Carroll, Jr., Cincinnati; William Oak Coss, Dayton; Walter

J. Cassidy, Jr., Trenton; August J. Cassini, Cincinnati; Nicholas S. Checkles, Great Lakes, Ill. (Toledo);

Warren W. Daudistel, Cincinnati (Hamilton); Robert L. Dernlan, Akron (Swanton); Richard K. Dickey, San Francisco, Calif. (Verona); Paul J. Ditmyer, Jr., Hamilton; Richard J. Dorger, Long Beach, Calif. (Cincinnati); Richard J. Drexelius, Long Beach, Calif. (Cincinnati);

William E. Ferris, Delaware; Arthur H. Fix, Jr., Portland, Oregon (Cincinnati); William R. Forney, Philadelphia, Pa. (Williamsburg); Donald B. Frazier, Cheviot (Cincinnati); John L. Friedman, Cincinnati; Robert D. Gillett, Grand Rapids, Mich. (Toledo);

David C. Henning, Cincinnati; Bernard D. Herring, San Francisco, Calif. (Massillon); William D. Heuer, Cincinnati; Robert Wood Higgins, Flint, Mich. (Akron); John C. Holmes, Cincinnati; Lenly T. Hopkins, Jr., Kansas City, Mo.; Donald W. Hopping, Dayton; James E. Huston, Denver, Colorado (Akron);

Roy Jett, Jr., Cincinnati; Kenneth Kreines, Cincinnati; Richard K. Lancaster, Denver, Colorado (New Richmond); James L. Leonard, Cincinnati; Albert L. Long, San Bernardino, Calif. (Cincinnati);

James J. Maurer, Cincinnati; Charles E. McCorkle, Jr., Sidney; Earl R. McLoney, Mechanics-town; Bonnie L. McNeely, Cincinnati;

Louis W. Menachof, Cincinnati; David Fischer Merten, Cincinnati; Jerry D. Moore, Long Beach, Calif. (Cincinnati); Richard S. Moraites, Cincinnati; Richard H. Morris, Cincinnati (North Bend);

Chester E. Nameth, Cincinnati; Stanley H. Nedelman, Cincinnati; Paul A. Palmisano, Norwood; Theodore J. Pavlick, Marietta; Thomas C. Putnam, Cincinnati; John R. Qualey, Bellevue, Kentucky;

William B. Rank, Cincinnati; Ernest G. Rolfes, Cincinnati; Marilyn J. Rousey, Cincinnati; William J. Rueger, Dayton;

Albert F. Samuelson, Milwaukee, Wisc. (Bismarck, N. D.); John D. Sawyer, Crestline; Frederick L. Schaefer, Cincinnati; John J. Schlueter, Cincinnati; Theodore C. Smith, Madison, Wisc. (Cincinnati); Harold B. Spitz, Cincinnati; Jack P. Steinhilber, Cincinnati (Piqua); Francis L. Stevens, Cincinnati (New Richmond); James F. Stewart, Cincinnati (Marietta);

Claude A. Taylor, Jr., Madison, Wisc. (Cincinnati); Francis M. Terada, Cincinnati (Honolulu, Hawaii); Ralph C. Tierney, Phoenixville, Pa. (Norwood); Lawrence Troum, Bayonne, N. J. (Elizabeth, N. J.); Gary M. Troup, San Francisco, California (Middletown); Alexander C. G. Van Dyke, Southgate, Ky. (Long Beach, Calif.);

James L. Wagstaff, Highland Park, Mich. (Galion); John P. Waller, Highland Park, Mich. (Aberdeen, S. D.); Richard G. Weber, Bangor, Maine (Marion); Henry E. Wedig, Jr., Cincinnati; Roy A. Wildey, Moscow, Ohio; Donald G. Williams,

The doctor who practices democracy is the doctor who votes November 6.

Cincinnati (Cleveland); Richard S. Wolf, Cincinnati; Robert J. Yingling, Martins Ferry.

WESTERN RESERVE UNIVERSITY—Marvin Abrams, Cleveland Hts.; Tony Adamle, Akron (Cleveland); Alan R. Alexander, Cleveland; James R. Armstrong, Rocky River (Lakewood); Edward R. Arquilla, Cleveland Hts.;

John W. Barrett, Rochester, N. Y. (Cleveland); John R. Blackman, Cleveland Hts. (Canton); Eugene W. Brickner, Tiffin; Richard H. Bright, Parma;

Ann C. Brown, Cleveland (Lorain); Robert B. Brown, Cleveland; Wilbur M. Brown, Carrolton; Frank O. Bruch, Cleveland; Roy E. Bugay, Parma (Cleveland); John Anton Bukovnik, Cleveland;

Robert F. Castle, Chapel Hill, N. C. (Cleveland Hts.); Wilma K. Castle, Cleveland Heights; William Cohen, East Cleveland (Brooklyn, N. Y.); Jack T. Collins, Cleveland Heights; Jo Ann Margaret Cornet, Chicago Hts., Ill.; Charles E. Couch, Akron; William S. Cumming, Cleveland Hts.;

Carl F. Doershuk, Youngstown; Edward G. Dowds, Parma (Shelby); Bernard V. Dryer, Cleveland; Harold B. Dull, Shaker Hts. (Connellsville, Pa.); Harold D. Erlenbach, Columbus (New London);

Howard E. Fagan, Cleveland (Painesville); Kevin J. Fenton, Boston (Akron); John Floyd, Cleveland Hts. (Mayview, Pa.); Thomas H. Gardner, Jr., Chapel Hill, N. C. (Cleveland); Allen P. Hartman, New York, N. Y. (Cleveland); Grant L. Heller, Cleveland (Dayton); Jack U. Hudson, St. Louis, Ill. (White Hall, Ill.);

Catherine C. Jarchow, South Euclid; Edward F. Jukes, Akron; Milton Katz, Farrell, Pa.; Uldis A. Knoch, Lakewood; John C. Kyle, Cleveland, (Akron); Donald D. Leonard, Akron; Harry H. Love, Cleveland (Brooklyn, N. Y.);

John D. Mackinnon, Bridgeport, Conn. (Hamilton); Benjamin P. Madow, Cleveland; David L. Mallett, Cleveland (Worthington); Alan M. Masling, Cleveland Hts.; Gerhard Nellhaus, Boston, Mass.; Horace B. Newhard, II, Wadsworth (Carey); Harry Nudelman, Shaker Heights;

Ray Charles Otte, Cleveland (Wellsburg, West Virginia); Stanley F. Patten, Jr., Shaker Heights; Alan D. Podis, Cleveland; Wayne L. Rockwell, Akron; Alan Roginsky, Brooklyn, N. Y. (Cleveland); Richard D. Rubin, Cleveland; Theodore A. Russell, Cleveland (Warren);

Paul W. O. Scharff, Cooperstown, N. Y. (Lorain); Donald B. Sodee, Washington, D. C. (Canton); George P. Sperry, Cleveland (Tallmadge); Harry B. Stults, Jr., Cleveland (Wooster); Frederick T. Suppes, East Cleveland; Eugene J. Swenson, Mexa, Arizona (Prova, Utah);

William H. Taake, Youngstown; Thomas M. Teree, Boston, Mass. (Paulding); Abba I. Terr,

Cleveland Heights; John T. Ungerleider, Cleveland;

Barry Q. Walker, Cleveland (Hartsdale, N. Y.); William G. Walker, Shaker Heights; Walt F. Weaver, Cleveland (Lincoln, Nebr.); Robert H. Williams, Cleveland Heights (Massillon); Bruce K. Willitts, Cleveland (Maplewood, N. J.); Merrill K. Wolf, Boston, Mass. (Cleveland); Richard M. Zirkin, Cleveland.

OUT-OF-STATE AND CANADIAN MEDICAL SCHOOLS (Arranged according to medical schools)—Melvin Moore, (Brooklyn, N. Y.)—Chicago Medical School; Herbert Mu Hak Nam, Cincinnati (Honolulu Hawaii)—Columbia Univ.; Harry M. Butler, Jr., Newark—Cornell University; Robert J. Gedert, Clyde—Georgetown Univ.; William L. Strickler, Sheldon, Ill.—Harvard; Raymond J. McMahon, Jr., Detroit, Mich. (Massillon)—Marquette; Alfred B. Jefferson, Columbus (Portsmouth)—Meharry; James D. Woodburn, II, Urbana—New York Medical College;

James M. Carhart, Columbus (Youngstown)—Northwestern; Thomas N. Gynn, Lakewood—Stritch School of Medicine; Mary A. Lenkay, Toledo—Stritch School of Medicine; John T. Murray, Lakewood—Stritch School of Medicine; Donald D. Brown, Cincinnati—Univ. of Chicago; Lawrence I. Gottlieb, University Hts.—University of Chicago;

Don E. Poulson, Cleveland—Univ. of Oregon; Herbert E. Croft, Butler, Penna.—Univ. of Pittsburgh; John R. Dille, Akron (Pittsburgh, Pa.)—Univ. of Pittsburgh; David E. Livingston, Portsmouth—Univ. of Rochester; James J. Lane, Jr., Cleveland (Three Forks, Montana)—Univ. of Washington; Elinor T. Christiansen, Worthington (Peking, China)—Women's Med. Col.;

John H. Campbell, Cleveland (Bridgewater, Nova Scotia)—Univ. of Ottawa; Albert H. Silverberg, Shaker Heights (Toronto, Canada)—Univ. of Toronto.

GRADUATES OF FOREIGN MEDICAL SCHOOLS (Arranged according to country in which medical school is located)—Sophia B. Chmielnicki, New York, N. Y.—Univ. of Vienna, Austria; Edward A. Hrowat, Cincinnati—Univ. of Graz, Austria; Wolfgang G. Nebehay, Euclid—(Vienna, Austria) Univ. of Graz; Theodosius Senkowsky, Philadelphia, Pa.—Univ. of Graz; Maria Henke, New York City—Univ. of Innsbruck, Austria; Jan S. Matthews, Chicago, Ill.—Univ. of Innsbruck; Edmund Strauss, Cincinnati—Univ. of Vienna, Austria;

Janie Tsai Lu Chang-Hwang, Columbus—Nat. Med. Col. of Shanghai; Yu-Ying Tsing Huang, Ithaca, N. Y. (Shanghai, China)—Tung de Academiae Med., Shanghai, China; Nathan Chong-Tsau Chang, Jersey City, N. J. (Ningpo, China)—W. China Union Univ.;

Charles C. Grossman, Pittsburgh, Pa.—Univ. of Bratislava, Czechoslovakia; Andrew Shawala,

Don't expect to vote November 7 in the November 6 election.

Hampton, N. J.—Univ. of Bratislava; Milorad Andrial, Norwood, Mass.—Univ. of Prague, Czechoslovakia; Adolph G. Baur, Chicago, Ill.—Univ. of Prague; Tamas A. Lanczy, State Hosp., New Jersey—Univ. of Prague;

Fabio Rodriguez, New York—U. of Santo Domingo, Dominican Republic; Hendrik Vannak, Detroit, Mich.—Univ. of Tartu, Estonia; John P. Kalfas, Reading, Pa.—Univ. of Paris; Andrius J. Bridzius, Cleveland—Univ. of Berlin; Stanley Hrynkiwich, Philadelphia, Pa.—Univ. of Berlin; Gerd-Welfhard Prowe, New York, N. Y. (Bonn, Germany)—Univ. of Bonn; Franz J. Nave, Corpus Christi, Texas (Breslav, Germany)—Univ. of Breslau; Murray A. Litton, Kilgore, Texas—Med. Academy of Dusseldorf;

John Chorny, Alton, Ill.—Univ. of Erlangen, Germany; Andreas Luciv, Chicago, Ill.—Univ. of Frankfurt/Main, Germany; Barbara B. Stein, Arlington, Va.—Univ. of Frankfurt/Main; Astis K. Freimanis, Columbus—Univ. of Hamburg; Harry E. Hartmann, McCain, N. C. (Heiligenstadt)—Univ. of Hamburg; Lusia S. Hornstein-Haraszti, Cincinnati—Univ. of Heidelberg, Germany; Stephan Hornstein-Haraszti, Cincinnati—Univ. of Heidelberg; Anastasia Kutt, Oak Forest, Ill.—Univ. of Heidelberg; Alex Latyshevsky, New York, N.Y. (Staten Island, N.Y.)—Univ. of Heidelberg; Hans L. Pollack, Ann Arbor, Mich.—Univ. of Heidelberg;

Gerhard Berner, Independence, Iowa—Univ. of Jena, Germany; Mark M. Ellen, New Brunswick, New Jersey—Univ. of Marburg, Germany; Gisela A. Munzinger, Cincinnati (Weingooote, Germany)—Univ. Marburg; Boris Borotinski, Fort Bragg, North Carolina—Univ. of Munich, West Germany;

Dimitri E. Gostimorovich, Cincinnati (Yugoslavia)—Univ. of Munich; Victor Koby, Columbus—Univ. of Munich; Eugene Meyer, Detroit, Mich.—Univ. of Munich; Jaroslaw Muzyczka, Canton—Univ. of Munich; Antoni Trzeciak, Center Line, Michigan—Univ. of Munich; Kazys G. Ambrozaitis, Cleveland—Univ. of Tubingen, Germany; Otto P. G. Preuss, Westfield, Mass. (Lima)—Univ. of Tubingen; Wolfgang Zeman, Columbus (Stuttgart, Germany)—Univ. of Tubingen;

Joseph Freidinger, Birmingham, Ala.—Univ. of Budapest; Frigyes Szaszler, Spencer, W. Va.—Univ. of Budapest; G. Fazekas, Cincinnati—Univ. of Debrecen, Hungary; Julius V. Molnar, Raleigh, North Carolina—Univ. of Debrecen;

Mauro M. DeGirolamo, Bronx, N. Y. (Italy)—Univ. of Bari; Ralph M. Rea, New York, N. Y.—Univ. of Bari (Italy); Louis Schiesari, Memphis, Tennessee (Padova, Italy)—Univ. of Padova; Salvatore Bucolo, New Brunswick, N. J.—Univ. of Palermo (Italy); Peter E. Canale, Crugers-on-the-Hudson, N. Y. (Italy)—Univ. of Palermo;

Verners Berzins, Dayton—Univ. of Latvia; John

Jurgilas, Chicago, Ill.—Univ. of Kaunas (Lithuania); Alfonsas Pakalniskis, Detroit, Mich. (Kaunas, Lithuania)—Univ. of Kaunas; Jekabs Kneziņskis, Hopkinsville, Ky.—Univ. of Latvia; Karlis N. Pope, Cleveland—Univ. of Latvia;

Raymond R. de la Pena, Elyria—Univ. of Nuevo Leon, Mexico; Manuel M. Rodarte, Cincinnati—Univ. of Nuevo Leon, Mexico; Roman A. Wojanowski, Buffalo, N. Y. (Poland)—Univ. of Poznan, Poland; David D. Krongold, Kew Gardens, N. Y. (Poland)—Univ. of Warsaw; Peter Ogden, Chicago, Ill.—Univ. of Warsaw; Victor Glikman, New York, N. Y.—State Med. Inst. Askhabad, Turkmenia, Russia;

Abramah Klar, Cleveland (Scotland)—Univ. of Edinburgh; Boleslaw D. Zietak, Cleveland—Univ. of Edinburgh; Nachman Kacen, Kew Gardens, New York—Univ. of Basle, Switzerland; Allan Chester, Cleveland—Univ. of Geneva, Switzerland; Shirley Z. Walsh, New York, N. Y.—Univ. of Geneva; Alexander Horava, Columbus—Univ. of Lausanne, Switzerland; Igor I. Borden, Cincinnati—First Med. School of Kharkov, Ukraine.

An Official Opinion of the Attorney General

The syllabus of an opinion given recently by Attorney General C. William O'Neill reads as follows:

"1. It is the duty of the sheriff to furnish, and the county commissioners to provide at the expense of the county, such medical treatment and hospitalization as may be necessary to the health of county prisoners sentenced to the county jail by a mayor's court or municipal court for violation of a state statute, provided, however, that if the court of common pleas has, by virtue of Section 341.06, Revised Code, prescribed rules governing the employment of medical or surgical aid for prisoners, such rules must be adhered to by the sheriff in furnishing such services. (Opinion No. 135, Opinions of the Attorney General for 1939, Paragraph 2 of the Syllabus: overruled.)

"2. It is the duty of a municipality to provide by ordinance for such medical treatment and hospitalization as may be necessary to the health of municipal prisoners sentenced to the county jail by a mayor's court or municipal court for violation of a municipal ordinance, provided, however, that if such municipality fails to provide for such care by ordinance, the sheriff shall obtain such care for municipal prisoners in the manner prescribed for county prisoners, and the municipality shall be responsible for the expense incurred in obtaining such services."—Opinion No. 6768.

The distance from the doctor's office to Washington is only as far as his polling place. Vote November 6.

You can't expect somebody else to elect your candidates. You must vote November 6.

United Mine Workers Fund Report for The Year Shows Substantial Increase in Balance

This year's annual report of the United Mine Workers of America Welfare and Retirement Fund shows the Fund had an unexpended balance of \$130,172,370.58 as of June 30, 1956, as compared with \$103,607,911.33 as of June 30, 1955, an increase of more than 26 million dollars.

Total revenues for the year were \$154,227,174.35.

Expenditures totalled \$127,662,715.10, of which 97.1 per cent or \$123,913,788.13 were payments aiding 206,919 beneficiaries; all administrative costs of the Fund, including those of its Washington headquarters and its 10 Area Medical Offices were 2.9 per cent of total Fund expenditures.

Of the total benefit expenditures for the fiscal year, pension payments were \$73,150,992.31. On June 30, there were 61,546 retired miners receiving the \$100 monthly pensions—which is in addition to Federal Social Security or other income the miner may enjoy. The average age of these pensioned miners at retirement was 63.8. They had worked an average of 32.3 years in the coal industry; more than 2,200 had worked 50 years or longer in the mines.

Fund expenditures of \$47,502,629.88 this fiscal year for hospital and medical care provided 1,530,430 days of hospitalization for 89,513 Fund beneficiaries. Medical and surgical services for these hospitalized cases entailed 1,460,030 visits by physicians. Additional services of specialists through 825,126 office and outpatient clinic consultations were provided beneficiaries thus referred for expert diagnosis and treatment in accordance with the professional procedures of the Fund's Medical Service.

During the past fiscal year, the Fund, under the direction of Dr. Warren F. Draper, Executive Medical Officer, opened a three-state network of 10 hospitals operated by the Miners Memorial Hospital Association.

Funeral Expense and Widows and Survivors Benefits of \$3,190,358.94 aided 7,320 widows, orphans and other survivors of deceased miners. Additional payments of \$69,807 in Mine Disaster Benefits aided families of 241 miners killed or seriously injured in mine disasters during the year.

The report shows that for a 10-year period benefits paid totalled \$880,819,489.10 and 972,004 beneficiaries—miners, their families, their widows and orphans—were aided. Revenues received during the decade totalled \$1,036,650,955.03.

Don't follow the parade to the voting booth election day. Lead it November 6.

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AMA-Sponsored Public Relations Meeting in Chicago Is Well Attended By Ohioans in Organization Work with Several Taking Part on Program

OHIO physicians and employees of organized medicine were afforded an opportunity to profit by the experiences of others in almost every field of public relations in Chicago August 29 and 30.

Occasion was the AMA's 1956 Public Relations Institute, with Ohio represented by four physicians, six full-time executives and an auxiliary member.

Public relations topics covered opening day included staging science fairs on the county, state and national levels, state and county orientation for the medical society newcomer, a premier of a new AMA membership film, "The Case of the Doubting Doctor," and effective speaking.

Also presented the first day were subjects covering family health records, newspaper advertising, doctor-lawyer relations, working with medical schools, opening a new state headquarters, traffic safety and accident prevention, representation on health organizations; Planning a centennial celebration, public relations value of lay awards, poison control, "pre-med" day for high school students, school health, a doctor distribution survey and manning health exhibits.

Topics for the second day were legislative relations and campaigns, the 1957 public relations outlook on county, state and national levels and medical profession participation in radio and television.

OHIOANS ON PROGRAM

Ohioans participating on various panels included:

George H. Saville, OSMA public relations director, moderator of a panel on legislation and legislative campaigns.

Dr. J. Robert Hudson, chairman, Cincinnati Academy of Medicine Public Relations Committee, who discussed an Academy-sponsored newspaper advertising series on the medical profession.

Hart F. Page, OSMA assistant director of public relations, and secretary to the OSMA School Health Committee, who spoke on school health programs.

Edward F. Willenborg, Cincinnati Academy of Medicine executive secretary, who outlined plans for the Academy's centennial celebration in 1957.

The entire scope of the institute was aimed at emphasizing the benefits gained from effective public relations, both through programs activated by medicine within its own organizations and

through lending assistance to organizations of laymen in associated fields.

OTHER OHIOANS

Others attending the institute from Ohio included:

Dr. E. E. Ash, Springfield, public relations chairman, Clark County Medical Society, and Mrs. Ash, an auxiliary member.

Dr. Ralph H. Jamison, Warren, public relations chairman, Trumbull County Medical Society.

Mr. Robert F. Freeman, Dayton, executive secretary, Montgomery County Medical Society.

Mr. M. John Hanni, Jr., executive secretary, Cleveland Academy of Medicine.

Charles W. Edgar, OSMA administrative assistant, and

Dr. John B. Chewning, director of professional relations, the William S. Merrell Co., Cincinnati.

Cleveland Chrysanthemum Ball Will Benefit AMEF Fund

Ohio physicians and members of their families are invited to attend the Chrysanthemum Ball sponsored by the Woman's Auxiliary of the Academy of Medicine of Cleveland on Saturday, November 17, in the Ball Room of the Statler Hotel, Cleveland.

Proceeds of this event will go for the benefit of the National Medical Education Fund.

Social Hour begins at 7:00 p.m. with dinner at 8:00. Dancing to the accompaniment of Ralph Barlow's Orchestra will continue until 1:00 a.m. Subscription is \$7.50 per person. Reservations should be made not later than November 13. Checks made out to the Chrysanthemum Ball or the Academy of Medicine of Cleveland should accompany reservations and be sent to The Academy office, 2009 Adelbert Rd., Cleveland 6, Attention Mrs. Henry J. John.

Aviation Medicine at OSU

The Air Line Pilots Association, with headquarters in Chicago, has established a \$7,200 fellowship in aviation medicine at Ohio State University, which is the first civilian institution to offer graduate training in this medical specialty. The program requires two years training on the campus and a third year as medical director of an air line or plane manufacturer. First appointee under the program is Dr. C. Craig Wright, a 1953 graduate of OSU who has served since in the Air Force Medical Corps.

Democracy can be spelled with four letters:
V-o-t-e. Do it November 6.

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*References and clinical trial supplies available on request.



Washington Roundup . . .

News From Nation's Capital of Interest to Physicians; Reports of Developments in Medical and Health Fields; Activities of Agencies

SELECTIVE Service has asked state directors to review files of all physicians in residency programs who have not requested deferment under military or Public Health Service residency training program. All three military services have programs under which physician subject to regular draft may seek deferment to take residency provided he selects specialty of value to armed services and accepts reserve commission. He must serve minimum of two years of active duty.

* * *

Competitive exams for regular Public Health Service Corps medical officer appointments scheduled in various sections of U. S. November 27-30. PHS says appointments are open for careers in clinical medicine, research, public health. Applications are made to: Chief, Division of Personnel, PHS, Dept. of Health, Education and Welfare, Washington 25, D. C.

* * *

Prediction is that 1957 will see Federal law controlling chemical additives in food to extent requiring full, adequate safety testing before additive is marketed.

* * *

Atomic Energy Commission has announced new methods for using atomic energy products and techniques to treat cancers. AEC also revealed plans for construction at Brookhaven National Laboratory, Long Island, of first reactor designed exclusively for medical research and treatment. Completion is due in 1958.

* * *

Public Health Service has announced new grants amounting to \$48,879,678 to medical schools, hospitals, universities and other non-federal institutions for research in allergy and infectious diseases, arthritis and metabolic diseases, cancer, dental research, heart, mental health, neurological diseases and blindness and NIH in general.

* * *

According to estimates reflected by plans of individual states, survey shows about 843,000 more hospital beds needed in U. S.

* * *

Expanding horizon of military medicine is to be theme of Military Surgeons of U. S. annual meeting in Washington, November 12-14. Meeting is to stress growing responsibilities of medicine and its associated discipline in federal medical services.

Despite some 69,000 decline in persons on relief, states and federal government listed \$66.9 million increase in spending for fiscal year ending June 30; total spending was \$2.79 billion for public assistance. Increase attributed to more aid to disabled and fact that some states hiked monthly payments to relievers.

* * *

Civil defense strategy is in for a major overhaul. Investigating committee provoked by some information a year-long probe developed. Michigan State University contracted to make national survey of civil defense organization on urban levels.

* * *

One out of every four Americans is attending school or college this year, according to U. S. Office of Education—a record enrollment for both levels of education. Office predicts college and university enrollment to double by 1970.

* * *

Paul C. Kitchin, D. D. S., professor, Ohio State University School of Dentistry, is a member of the 12-man advisory council that will aid the Public Health Service in administering three-year, \$90 million grants program for building non-Federal research facilities.

* * *

Small Business Administration is receiving grants and is prepared to loan up to \$250,000 per borrower for expansion, improvements and working capital applied for by privately-owned hospitals, nursing homes and medical and dental laboratories. Applicant must satisfy professional and financial requirements before he is eligible for a loan. Interest rate is 6 per cent. In Ohio, application blanks are available at SBA's Cleveland office.

* * *

Information is being gathered, at Congressional request, on practicability and probable cost of a program of basic health insurance for U. S. civilian workers, financed partly through payroll deductions, partly through Federal contributions. Plan is opposed by Blue Cross, Blue Shield, American Hospital Association and some labor spokesmen.

* * *

National Science Foundation reports 38 Federal agencies engaged in various types of research and collection of scientific data, with 130,000 scientists employed. Cost of over-all Federal research put at more than \$2 billion a year.

Changes in Mortality Pattern . . .

Paradoxically the Increasing Span of Life and Changes in Patterns Of Disease Have Not Diminished Need for Continuing Medical Care

HERE are some interesting facts on changes in leading causes of deaths since the turn of the century as excerpted from a leaflet of the Health Information Foundation, 420 Lexington Avenue, New York, followed by comments by its president:

* * *

The death rate in the United States has declined nearly 46 per cent since the turn of the century. Although this dramatically emphasizes the general progress of the past 50 years, it nevertheless obscures the real significance of the change in the nation's mortality pattern.

Shortly before 1900 health research entered the so-called bacteriological era when the primary concerns were identification and classification of the communicable diseases, their modes of transmission and the methods that would bring them under control. The very success of this era in science is a landmark in the health progress of our nation. Within the lifetime of many of us the communicable diseases have been virtually eliminated as leading causes of death.

Although there are many ramifications of this progress, this discussion is limited to a discussion of the two basic trends in causes of death that characterize mortality changes in the United States since 1900: First, the leading causes of death today are the non-communicable diseases (mainly degenerative conditions) and accidents, whereas at the turn of the century, the communicable diseases were of greater relative importance. Second, a smaller number of leading causes account for increasing proportions of total deaths with each successive decade.

COMMUNICABLE DISEASES

In 1900 the three leading causes of death were communicable diseases—pneumonia-influenza, tuberculosis and the disease group which includes diarrhea, enteritis and infective ulceration of the intestines. These diseases accounted for slightly over 31 per cent of all deaths in 1900. By 1954, however, medical progress had reduced this toll to less than 5 per cent of our total deaths.

Pneumonia-influenza was the major killer in

1900 and remained as either the first or second leading cause of death through 1930. During this time, however, the death rate from this cause dropped sharply, the 1930 rate being about one-half the 1900 rate. By 1940 pneumonia-influenza had dropped to sixth place, and by 1954—as a result of the continuing, rapid decline—it had dropped to seventh place. Even when adjustments are made for changing definitions, the death rate for pneumonia-influenza had dropped an amazing 86 per cent since the turn of the century.

Tuberculosis—the second leading cause of death in 1900—has experienced an even greater decline. During the decades beginning with 1910 and 1920 it dropped from second to third place; by 1930, it was in seventh place, and by 1954, it was off the list of 10 leading causes of death. During the period 1900-1954 the tuberculosis death rate declined 95 per cent. A 100 per cent decline, obviously, would mean that deaths from this cause would have been completely eliminated.

THE ENTERITIS GROUP

The death rate of the third major killer in 1900, diarrhea, enteritis and ulceration of the intestines, has had an overall decline of 96 per cent since the turn of the century. The same pattern of decline has been followed by the other

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two communicable diseases that were among the 10 leading causes in 1900, diphtheria and bronchitis. Both diphtheria and bronchitis dropped from the 10 leading causes by 1910, bronchitis showing a 96 per cent decline in death rate and diphtheria over a 99 per cent decline.

HEART DISEASE AND CANCER

The increasing importance of the non-communicable causes of death since 1900 is a corollary of the remarkable decline of the communicable diseases. From 1900 to 1954, diseases of the heart—now the leading killer—rose from fourth to first place. In 1954, over one-third of all deaths in the United States resulted from this single cause. Although heart diseases are generally associated with the older ages, nearly 12 per cent of all deaths among persons 25 to 34 resulted from these disorders.

Cancer and other malignant tumors made an even greater jump in rank, from eighth place in 1900 to second in 1954. At the turn of the century, only 3.7 per cent of all deaths resulted from cancer, whereas in 1954 this disease claimed 16 per cent of the total. Cancer, like heart disease, is usually associated with older ages; but it kills more children ages 5 to 14 than does polio.

The other degenerative diseases also are becoming more important as causes of death, although they account for a much smaller proportion of total deaths than either heart diseases or cancer. The death rates for vascular lesions (a category which includes cerebral hemorrhage) and hypertension and arteriosclerosis have remained relatively constant even though they cause a higher percentage of deaths because of the declining importance of the communicable diseases. The death rate from diabetes increased from 11 per 100,000 in 1900 to 27 per 100,000 in 1954. Nephritis, on the other hand, has shown a decline in rate.

Cause-specific death rates are an accurate measurement of the relative importance of the various causes of death at different times. Still, the meaning of changing rates cannot be taken on face value. The degenerative causes of death, for example, are associated with older people, and now that increasing proportions of our population are living to the higher ages, more individuals become subject to these causes of death. Cause-specific death rates naturally reflect this change in the composition of our population. But even when the changing age structure is taken into account, basic patterns in mortality remain the same.

PERSPECTIVE

It is possible, of course, to view these data from another perspective—not in terms of death rates from specific causes—but as single causes of death in proportion to total deaths. Causes of death which have not been controlled now inevitably account for higher percentages of gross mortality. This is a direct result of the decline

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PROLONGED

ACTION For days following each injection

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HORMOGEN R-A: Aqueous suspension in 10 cc. multiple dose vial: each cc. represents Estrone U.S.P. 2 mgs., Potassium Estrone Sulfate 1 mg.

INDICATIONS: Menopause syndrome, for control of uterine bleeding of endocrine origin, senile vaginitis, kraurosis vulvae and puritis vulvae.

DOSAGE: ½ cc. to 1 cc. once or twice a week.

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of communicable diseases as causes of death. And the non-communicable disorders are becoming increasingly important and are causing a greater proportion of total deaths.

The curbing of deaths from communicable diseases provides an amazing record of health progress. On the other hand, in granting us longer life, this progress has also brought the pressing problems of degenerative diseases which are frequently of very long duration and are growing as causes of mortality. Future mortality declines, then, must depend upon new advances in research and therapy which will reduce the non-communicable causes of death.

AN INCREASING NEED FOR MEDICAL CARE

The foregoing factual report by the Health Information Foundation was compiled from material furnished by the National Office of Vital Statistics. With the report as a background, George Bugbee, president of the Foundation, presented the following comments:

Now that heart disease, cancer and other degenerative disorders have displaced the communicable causes of death in the United States, there is good reason to evaluate their effects on modern medical care. The most prevalent causes of sickness, which we would not want to confuse with leading causes of death, are not necessarily less important. But, behind the leading causes of death are the illnesses which now warrant our greatest personal attention, our primary efforts at medical research, our latest techniques of patient care in the hospital and our best efforts at research in the social and economic aspects of health.

The hard truth is that although fewer causes of death now account for a larger proportion of total deaths, and although deaths are far fewer per 1,000 population each year than they were 50 years ago, we have by no means decreased the need for medical care. On the contrary, even with infectious diseases much diminished as killers, we spend as many days per 1,000 population in general hospitals as we did 25 years ago. Diseases which rarely cause death still require much medical care. And now that we are living longer, we become subject to the long-term, degenerative illnesses—illnesses which make heavy demands on physician time, require a total of more hospital care and other medical services and entail more expense than did many communicable diseases at their very worst.

As a result, the changing patterns in causes of death bring greater responsibilities to the individual in terms of his own health. These responsibilities—a better understanding of why we should seek medical care at the time it will be of greatest value and the necessity of budgeting to meet the costs of care—are within the primary objectives of Health Information Foundation.

Don't look around for somebody else to blame if you fail to vote November 6.

Cook County Graduate School of Medicine

INTENSIVE POSTGRADUATE COURSES

Starting Dates—Fall, 1956

SURGERY—Surgical Technic, two weeks, Oct. 29, Nov. 26. Surgery of Colon & Rectum, one week, Oct. 15, Nov. 26. General Surgery, one week, Oct. 29. General Surgery, two weeks, Nov. 5. Breast & Thyroid Surgery, one week, Oct. 22. Gallbladder Surgery, 3 days, Oct. 29. Fractures & Traumatic Surgery, two weeks, Oct. 15.

GYNECOLOGY & OBSTETRICS—Office & Operative Gynecology, two weeks, Oct. 22. Vaginal Approach to Pelvic Surgery, one week, Oct. 15. General and Surgical Obstetrics, two weeks, Nov. 5.

MEDICINE—Electrocardiography & Heart Disease, two-week basic course, Oct. 8. Gastroenterology, two weeks, Oct. 22. Dermatology, two weeks, Oct. 15. Cardiology (Pediatric), two weeks, Nov. 5.

RADIOLOGY—Diagnostic X-Ray, two weeks, Nov. 26. Clinical Uses of Radioisotopes, two weeks, Oct. 8.

UROLOGY—Two-week course, Oct. 8. Cystoscopy, ten days, by appointment.

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CHICAGO 12, ILLINOIS

"Patients without primary renal disease, but with albuminuria and high nonprotein nitrogen due to congestive circulatory changes, can be adequately and safely treated with Neohydrin for long periods of time."*

*Griffith, G. C.; Dimitroff, S. P., and Thorner, M. C.:
Ann. Int. Med. 45:7, 1956.

07656

Endocrines and Nutrition To Be Discussed at Ann Arbor

Links between the functioning of key human glands and nutrition will be probed by some of the nation's leading scientists at a Symposium on Endocrines and Nutrition to be held at the University of Michigan, Ann Arbor, Thursday and Friday, October 11 and 12. It is sponsored by the Medical School of the University of Michigan in conjunction with the National Vitamin Foundation. Those interested may obtain further information by addressing Dr. Frank H. Bethell at the University of Michigan, The Thomas Henry Simpson Memorial Institute for Medical Research, Ann Arbor, Michigan, or from The National Vitamin Foundation, 15 East 58th Street, New York 22, New York.

Two Health Films Available For Public Showings

The AMA Film Library recently acquired two nontechnical films that explain the functions of the heart and endocrine glands. Both films may be understood by any lay audience. Designed primarily for college hygiene and health education classes, these films are excellent teaching devices for any public group a medical society might wish to reach.

(1) "Common Heart Disorders and Their Causes"—functions of a healthy and disordered heart are demonstrated in this 17-minute film. One of the unique aspects is that it stresses the fact that people with heart disease are able to live long lives without seriously limiting their activities.

(2) "Endocrine Glands—How They Affect You"—this film locates and describes the eight endocrine glands and explains the function of the hormones these glands secrete. The 15-minute film studies the effects of these hormones on growth, metabolism, sexual development and behavior and shows what happens when the flow of certain hormones is increased or decreased.

Plaque Honors Dr. Peterson

President Eisenhower's Committee on Employment of the Physically Handicapped has given the American Medical Association a memorial plaque honoring the late Dr. Carl M. Peterson for his lifetime devotion "to the increased health, welfare and employment opportunity of his fellowman."

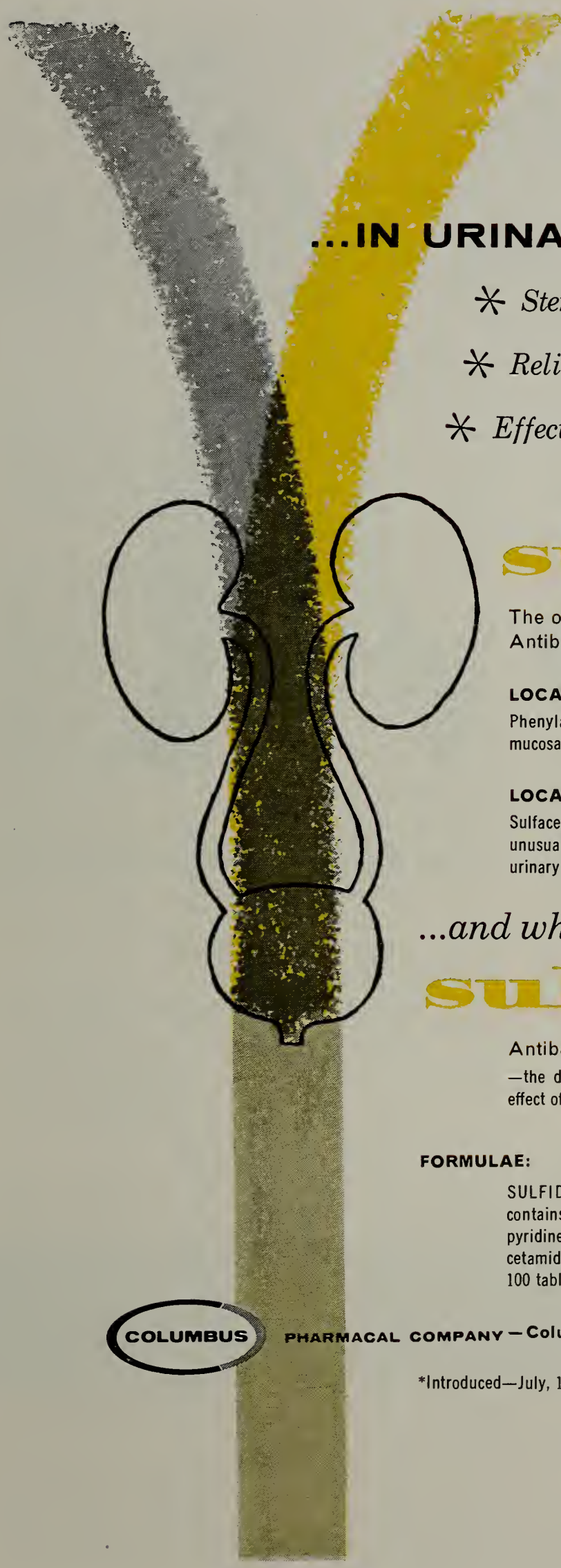
Dr. Peterson was secretary of the AMA's Council on Industrial Health for 17 years and served as chairman of the medical committee of the President's Committee. He died last fall of injuries suffered in a plane crash in North Carolina.

A first class doctor must be a first class citizen—and a first class citizen is one who votes. Do it November 6.

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In Our Opinion:

Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

SCHOOL OFFICIALS SHOULD DISREGARD LASZLO LETTERS

A number of Ohio physicians have asked the Columbus Office for information regarding the Dr. Erno Laszlo Foundation (for skin research and education) of New York City which has been circulating literature to certain Ohio school officials. The literature talks about "the disfigured skin of adolescence" and offers a proposition to the schools. It says it will offer counsel and skin education to those children whose parents can pay and will make "grants," in cases which can't afford to pay, for medical examination, treatments, medication, etc.

School officials would be wise to disregard the Laszlo letters for the following reasons:

If children or their parents need medical advice and assistance on skin diseases they should contact their family physicians or contact some specialists in their home city or area. Certainly diagnosis and treatment of diseases by mail is not a sound procedure. There is reason to believe that the organization is in the commercial business of selling cosmetics and certain medicines and doing a mail-order beauty guidance business. There is no substantial evidence that the organization has good medical guidance. There is grave doubt that the organization could possibly make good on its promise to finance services for children in the low economic group. There are many other ways and means locally of assisting such families. It is exceedingly difficult to deal with an organization as far away as New York especially when so few facts are known about it.

WEALTH NOT NECESSARY TO GET MEDICAL EDUCATION

Too often one hears the statement: "Only the rich man's son can afford a medical education today." It's not so and statistics prove that it isn't.

Figures from the Association of American Medical Colleges show that last year the largest group of medical students (33 per cent) came from families in which the father was a laborer or in the lower levels of business. Only 10 per cent were children of physicians, while 25 per cent were children of executives or men in managerial positions and 16 per cent of persons in professions other than medicine. The fathers of 16 per cent were deceased, retired, unemployed or their occupations not indicated.

The most important sources of students' income in 1955-56 were vacation earnings, personal earnings of the student during the year, earnings

of the student's wife, gifts from parents and the G. I. Bill. The largest average amount of income was wives' earnings. Eighteen per cent of the students reported that their wives' earnings, averaging \$2,500, was the largest source of income.

INTERESTED IN SMALLER TAX BILL?

See by the papers where a drive is on to get the next Congress to take favorable action on more of the recommendations made by the Hoover Commission, which recommendations if put into effect would save about \$5.5 billion a year in government spending.

Here is one example. The commission in its study of government methods of purchasing food and clothing for the armed forces and other agencies found evidence to prove the following statement: "There is still 10.6 years supply of women's (WAC) wool serge uniforms that were purchased during World War II. A stock card in Brooklyn indicates 100 years' supply of Waves hats." Savings in this one category would total \$400 million a year.

Savings such as these are worth putting into effect, in our opinion.

It will take pressure from citizens back home to get Congress to act.

BETTER GET THIS PAMPHLET AND PUT IT TO USE

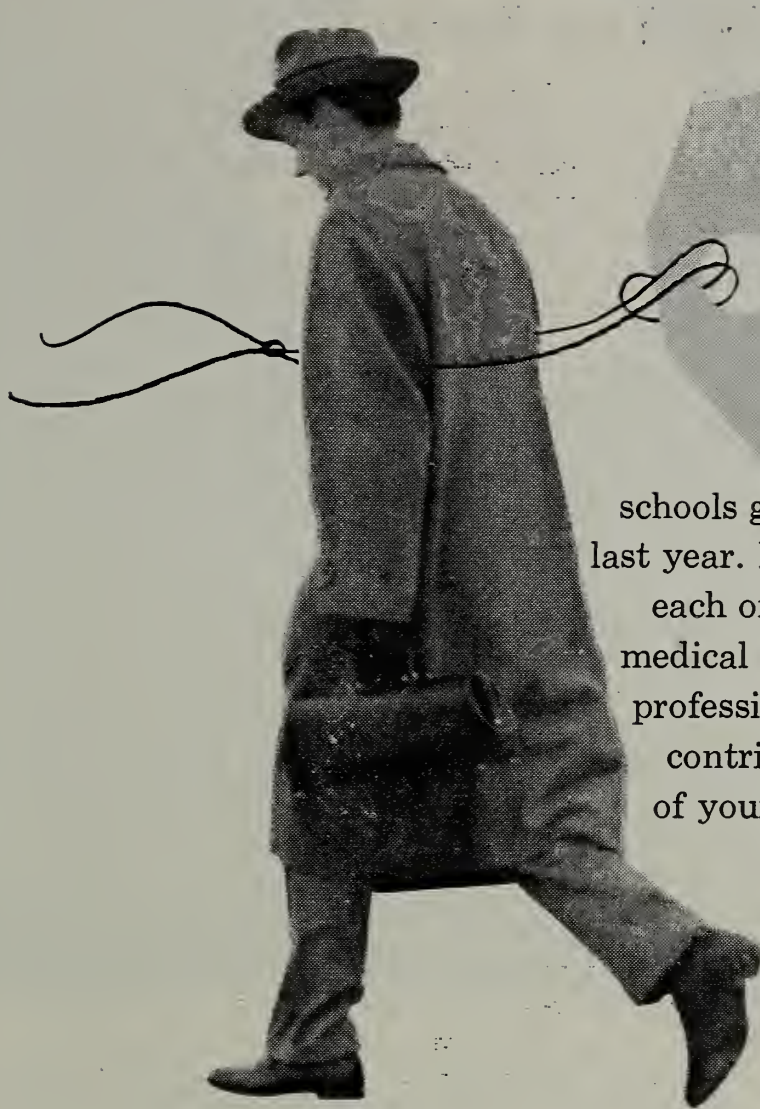
An American Medical Association booklet, "To All My Patients," is helping to achieve the patient's understanding and appreciation of his physician's services, so we recommend its use by all Ohio physicians. It explains many of the questions in the minds of patients about medical procedures and customs.

One million copies of the publication were prepared and printed last October by the AMA Public Relations Department, and total distribution, with a third printing, exceeds three million.

Originally intended for placement on tables in doctors' waiting rooms, the booklet was more effective if handed directly to the patient, most physicians found.

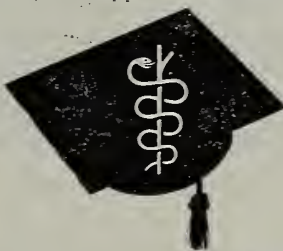
But a New York City physician, an ophthalmologist, wrote AMA of its effectiveness as a bill stuffer as follows:

"On Jan. 31, my secretary placed a copy of your booklet, 'To All My Patients,' in the same envelope in which a bill was enclosed. We feared at the time that the bill might be overlooked as advertising matter. However, we felt the idea



\$13,356

America's medical schools graduated 6,845 new doctors of medicine last year. It costs more than \$13,356 to train each of them. Most of this becomes medical school operating deficit which we as a profession must help meet. We will send your contribution along to the medical school of your choice if you prefer.



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"Within a few days, checks in payments of bills came through from more than twice the number of patients expected. This calculation is based on more than 10 years of observation.

"One patient congratulated me on the contents of the pamphlet when he came in to pay his bill; another not only did the same but explained that he was impressed by the simplicity of language, and he asked if I were going to follow this up with another pamphlet along the same line."

Doctors interested in obtaining copies of "To All My Patients" may do so by writing to Ohio State Medical Association headquarters or to the AMA Public Relations Department, 535 N. Dearborn Street, Chicago.

MAKING RECORDS AVAILABLE TO COLLEAGUES

The Judicial Council of the AMA has supplied an answer to this question which comes up frequently in a physician's practice: "A colleague has asked me to send him my records concerning a former patient of mine who presently is under his care. Am I obligated to send him these records?"

Here's what the Judicial Council had to say in effect:

The interest of the patient is paramount in the practice of medicine, and everything that can reasonably and lawfully be done to serve that interest must be done by all physicians who have served or are serving the patient. When a colleague who is presently treating a patient requests records from another physician who has formerly treated the patient, that former physician should promptly make his records available to the attending physician.

No set rule can be laid down to cover the manner in which the records are to be transmitted to the attending physician. Under some conditions a personal inspection of the records might suffice; under others an oral report of what is contained in the records would be of help, or in other circumstances a summary of the records might be made. In extreme cases, a physician might lend his complete record to the attending physician. The manner of making the report—or the information contained therein—available to the succeeding physician is immaterial and will depend on the circumstances of each case. Certainly, however, the attending physician should not demand or expect more information from the former physician than is necessary to give the patient adequate care in the present illness.

The Judicial Council assumes, of course, that proper authorization for the use of these records would be granted by the patient.

Put a big circle around November 6 on your calendar.

Do You Know? . . .

Dr. David Tucker, Jr., professor of medical history at the University of Cincinnati College of Medicine, was scheduled to represent the school at the 15th International Congress of the History of Medicine in Madrid, Spain, September 23-29. He also will visit other European medical schools where he will study admission practices.

* * *

Mr. Milton Golin, a Chicago newspaperman since 1942, has joined the *AMA Journal* staff as an assistant to Editor Austin Smith. His job will deal primarily with the reporting of significant non-scientific developments in medicine.

* * *

Dr. Sidney Franklin, Youngstown and Cleveland physician and attorney, was elected second vice-president of the American Board of Legal Medicine, which met concurrently with the American Medical Association in Chicago in June. Dr. Franklin addressed the group at that time on the subject, "The Medicolegal Aspects of Public Health."

* * *

Dr. Charles H. Hendricks, associate professor of obstetrics and gynecology at Western Reserve, has been awarded the 1956 Foundation Award of the American Association of Obstetricians and Gynecologists for his research on lactic acid metabolism in pregnancy and labor. Dr. Allan C. Barnes, chief of ob-gyn services at Reserve, won the award in 1952. That makes the Reserve department the only one in the nation with two winners of the prize.

* * *

Dr. Louis Wolff, of the Harvard Medical School faculty, is scheduled to speak on "Differential Diagnosis of Chest Pain" at a meeting of the Fort Steuben Academy of Medicine at 8:15 p. m. October 9 in Fort Steuben Hotel, Steubenville.

* * *

Dr. Anton J. Carlson, international figure in the field of physiology, research and nutrition, and recipient of the American Medical Association's distinguished service award in 1953, died at the age of 81 in Chicago September 2. He was the father of Dr. Alvin J. Carlson, of Oakwood and Dayton.

* * *

Dr. Harvey B. Stone, Baltimore, former member of the AMA Council on Medical Education and Hospitals, has replaced Dr. Allan Gregg, New York, on the National Advisory Committee to the Selective Service System in Washington.

* * *

Of the more than 150,000 people employed in atomic energy plants throughout the United States, at least 99.7 per cent are now considered as standard risks for life insurance, requiring no extra premium due to any atomic hazard, the Institute of Life Insurance reports.



ORAL PENICILLIN FOR BETTER AND MORE CONSISTENT ABSORPTION

*"Because of the better and more consistent absorption of penicillin V from the intestinal tract, it would appear that this type of penicillin is preferable to penicillin G when oral administration is to be used."*¹

1. Martin, W. J., et al.: J.A.M.A. 160:928 (March 17) 1956.

PEN•VEE•Oral and PEN•VEE Suspension permit new dependability in oral-penicillin therapy—dependable stability in gastric acid, dependable and optimal absorption in the duodenum. "Not being destroyed by acid in the stomach, as is penicillin G, penicillin V remains available in larger amounts for absorption."¹

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New Members of OSMA

The following are the names of the new members of The Ohio State Medical Association since August 1, 1956. The list shows the county in which they are affiliated, city in which they are practicing, or temporary addresses in cases where physicians are taking postgraduate work.

ATHENS COUNTY

Stephan E. Simay,
Nelsonville

CUYAHOGA COUNTY

Lewis F. Bissell, Aurora
Edgar S. Bowserfield, Jr.,
Cleveland
Joseph Costantini,
Cleveland
William E. Donze, Berea
Melvin L. Eckhouse,
Cleveland
Joseph G. Erossy,
Cleveland
Grant L. Franklin,
Cleveland
Arnold B. Friedman,
Cleveland
Paul M. Fumich, Cleveland
Joseph G. Furey, Cleveland
John P. Hudak, Cleveland
Paul J. Kalla, Cleveland
R. Riggs Klika,
Maple Heights
Norman J. Kozekoff,
Cleveland
Henry J. Lantner,
Cleveland
James H. Lavrich,
Cleveland
John Liambeis, Cleveland
Isador J. Lidsky, Cleveland
Margaret A. MacLachlan,
Cleveland
Walter A. Mendyka,
Cleveland
Joseph Nurenberg,
Cleveland
Lawrence B. Ogrinc,
Cleveland
Theodore V. Parran,
Cleveland
Franklin H. Plotkin,
Cleveland
Marvin Rollins, Cleveland
Jerold M. Rosenblum,
Cleveland
Jonas Sandargas,
North Royalton

Nicholas M. Sekerak,
Berea
Gerard Seltzer, Cleveland
Joseph V. Sharrota,
Maple Heights
Jonathan R. Smith,
Cleveland
Cyrus W. Stimson,
Cleveland
Harold L. Unger, Cleveland
Clay W. Whitaker,
Cleveland
Paul E. Wisenbaugh,
Cleveland

FAIRFIELD COUNTY

Robert E. Whetstone,
Pleasantville

HAMILTON COUNTY

Allan Brisker, Cincinnati
Robert C. Clear,
Cincinnati
Robert J. Kalthoff,
Cincinnati
Robert A. Kemper,
Cincinnati
Robert P. Koenig,
Cincinnati

HARDIN COUNTY

Wendell I. Zaring, For st
HOLMES COUNTY
Charles H. Hart,
Milersburg

LUCAS COUNTY

Edward Dranginis, Toledo
Robert N. Evers, Toledo
Michael Linver, Toledo
Adolph Wolferman, Toledo
James G. Sullivan, Toledo

MONTGOMERY COUNTY

John R. Keys, Dayton
William J. Shine, Dayton

SCIOTO COUNTY

Jerome N. Rini, Portsmouth

Toledo Hospital Gets Grant For Leukemia Research

Mr. R. W. Burger, president of the John A. Hartford Foundation, Inc., has announced a grant of \$162,075 to the Toledo Hospital for a three year study of causes and treatment of leukemia. The study will be conducted under the direction of Dr. Bernhard Steinberg, director of the Toledo Hospital Institute of Medical Research, in conjunction with a group consisting, in part, of a clinical hematologist, Dr. M. A. Atamer, and a biochemist, Dr. Leon Libenson.

The contemplated investigation is a transference of the basic research done at the Research Institute for the last eleven years.

A postgraduate course, in pediatric allergy comprising 30 weekly periods has been announced by New York Medical College, Fifth Avenue at 106th Street, New York 29, beginning November 7. The program will be under direction of Dr. Bret Ratner, professor of clinical pediatrics and associate professor of immunology.

Progress Report Given on Incidence Of Poliomyelitis in Ohio

With the polio season well advanced in mid-September, some interesting data were shown by the 371 cases reported to the Ohio Department of Health since the first of the year. A continuing study is in progress to relate the picture in Ohio with that of the nation as a whole and to interpret the incidence of the disease in terms of the preventive program being carried on.

Of the 371 cases of polio reported, 123 cases were paralytic, 170 nonparalytic and 69 unspecified or not classified at the time. There were 5 deaths from polio in the state, none of the victims of which had had Salk vaccine.

Of the 371 cases, 77 patients were children who had had one or two shots of vaccine. Of these 77, there were 28 paralytic cases, 47 nonparalytic and 2 unknown.

Dr. Ralph E. Dwork, director of the Ohio Department of Health recently announced in a memorandum to health commissioners that second and third shots be given to children in all age groups as soon as such inoculations are due according to schedule.

He has further recommended that adults between the ages of 20 and 35 avail themselves of Salk vaccine inoculations by visiting their physicians. Such adults must be given vaccine purchased through commercial channels. The free vaccine purchased with Federal grant allocations is authorized only for children through age 19 and pregnant women.

AMA Sponsors American Surgical Materials Association

The Board of Trustees of the American Medical Association has approved sponsorship by the AMA of the American Surgical Materials Association, in cooperation with the American Academy of Orthopaedic Surgeons, the American Hospital Association, and the American College of Surgeons.

The primary function of the organization is the development and revision of standards for surgical materials and the evaluation of products that meet these standards. The American Surgical Materials Association would be organized as a so-called membership nonprofit corporation under the laws of Illinois and would have a 15-member board of directors, composed of representatives of the four sponsoring organizations and the three classes of membership: (1) professional and technical, (2) industrial, and (3) associate.

The board of directors, in addition to being vested with the general administration of the organization, would authorize the adoption of standards and the acceptance of products. However, no member of the board who represented a manufacturer or fabricator would be permitted to vote on either of these matters.

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Bumbalo, T. S., Gustina, F. J.,
and Oleksiak, R. E.:
J. Pediat. 44:386, 1954.

White, R. H. R., and
Standen, O. D.:
Brit. M. J. 2:755, 1953.

against **ROUNDWORMS**

"Ninety per cent of the children passed all of their ascarides . . ."

Brown, H. W.:
J. Pediat. 45:419, 1954.

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In Memoriam . . .

Marshall H. Aiken, M.D., Tiffin; Western Reserve University School of Medicine, 1934; aged 48; died August 3; member of the Ohio State Medical Association and the American Medical Association. Dr. Aiken had been a practicing physician in Tiffin for 18 years. He was a member of the Elks Lodge, the Methodist Church, United Commercial Travelers, Rotary Club and the Seneca County Health Association. Surviving are his widow, a son and a brother.

Van F. Barrett, M.D., Lakeview; Western Reserve University School of Medicine, 1895; aged 88; died August 31; member of the Ohio State Medical Association and the American Medical Association; recipient of the Ohio State Medical Association's 50-Year Award. Dr. Barrett practiced medicine for almost 60 years in the Indian Lake area of Logan County. He was a member of the Masonic Lodge and the Methodist Church and former member of the local board of education. Survivors include two sons, one of whom is Dr. Charles L. Barrett, of the Indian Lake area and Bellefontaine.

Fred W. Brosius, M.D., Troy; Ohio State University College of Medicine, 1909; aged 72; died August 14; member of the Ohio State Medical Association and the American Medical Association; past-president of the Butler County Medical Society; member of the American College of Anesthetists. Dr. Brosius practiced in Middletown for about 40 years before he retired in 1952 and moved to Troy. In addition to his professional work, Dr. Brosius was active in civic affairs of the Middletown area. He was a member of the YMCA, the Civic Association, Rotary Club and served as a member of the Middletown Board of Education and trustee of the Middletown Public Library. He was a longtime member of the Presbyterian Church and several Masonic orders. Surviving are two daughters, a sister and a brother.

William D. Cunningham, M.D., Columbus; University of Illinois College of Medicine, 1901; aged 84; died August 27; member of the Ohio State Medical Association through 1944. Dr. Cunningham began his practice in Girard in 1902 and continued in the Trumbull County community until 1942, when he retired and moved to Columbus. Active in community affairs, he served three terms as mayor of Girard and also served as health commissioner. He was a veteran of the Spanish-American War. Survivors include his widow, a daughter and a sister.

Samuel A. Marshall, M.D., Jeffersonville; Medical College of Ohio, Cincinnati, 1882; aged 98; died August 3. Dr. Marshall practiced in Canton until 1900 when he moved to his farm near

Jeffersonville, later moving into Jeffersonville. He made his residence with two nieces.

Earl Cletus Mast, M.D., Mansfield; Columbia University College of Physicians and Surgeons, 1937; aged 51; died August 19; member of the Ohio State Medical Association, the American Medical Association and the American Society of Anesthesiologists. Dr. Mast had been a practicing physician in Mansfield for the past 17 years. He was a member of several Masonic bodies and the Baptist Church. Survivors include his widow, two daughters, three sons, his mother and five sisters.

Brice F. Metcalfe, M.D., Greenville; Medical College of Ohio, Cincinnati, 1899; aged 82; died August 3; in 1949 was presented 50-year pin and certificate by OSMA, and honorary lifetime membership in Darke County Medical Society. He practiced in Carrollton, Ky., before moving to Greenville in 1903. Dr. Metcalfe was associated with the Masonic Order 53 years. Survivors include his wife, a daughter, a son and eight grandchildren.

Joseph Edward Pirrung, M.D., Clifton; Miami Medical College, 1906; aged 73; died August 24; member of the Hamilton County Medical Society through 1939, a member of the American College of Surgeons. A practicing physician in the Cincinnati area for many years, Dr. Pirrung was a veteran of World War I and a member of the American Legion. Surviving are a daughter and two brothers.

Herbert A. Thomas, M.D., Lima; Western Reserve University School of Medicine, 1909; aged 76; died August 17; member of the American Medical Association, the Ohio State Medical Association, the Allen County Academy of Medicine, American Academy of Medicine and the Radiological Society of North America, Inc. Dr. Thomas was chief of the radiological department of Lima Memorial Hospital at the time of his death. He was a member of several Masonic Orders and a member of Lima Trinity Methodist Church and its board. He served on the Allen County Selective Service Board during World War II. He was listed as the first roentgenologist of the Lima area. He practiced briefly in Lima in 1910, moving to Lakeview where he practiced for three years before returning to Lima in 1913. Surviving are his wife, a son, a daughter and four grandchildren.

Veterans Administration announced it has developed a plan for career residency training in anesthesiology for full-time physicians in order to overcome the acute shortage of certified anesthesiologists in VA's Department of Medicine and Surgery.

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Activities of County Societies . . .

BELMONT

A business meeting of the Belmont County Society was held on September 20 in the Martins Ferry Hospital following dinner.

CLERMONT

"Differential Diagnosis of Jaundice" was the subject discussed at the September 19 meeting of the Clermont County Medical Society. Guest speaker was Dr. Joseph N. Ganim, Cincinnati. The meeting was held at the DX Ranch with Dr. O. C. Davison as host.

FAIRFIELD

The regular meeting of the Fairfield County Medical Society was held on September 11. After a short business meeting, Dr. Thomas Boles, addressed the Society on "Congenital Deformities of the Gastrointestinal Tract." Dr. Boles is on the surgical staff of University Hospital and Children's Hospital in Columbus. Dr. W. D. Nusbaum was the program chairman. Thirty-five members or 67 per cent were present.

HAMILTON

The annual meeting of the Academy of Medicine of Cincinnati was held on September 18. At that time the retiring president, Dr. Charles A. Sebastian, turned over the gavel to incoming president, Dr. Howard D. Fabing. Presentation of standing committee reports also was a feature of the meeting.

The Academy has announced the following coming meeting features:

October 2—"Accreditation of Hospitals," Dr. Kenneth B. Babcock, director of the Joint Commission on Accreditation of Hospitals, Chicago.

October 16—Joint meeting with the Cancer Council. "Preclinical Carcinoma," Dr. John R. McDonald, head of the Section of Surgical Pathology, Mayo Clinic, Rochester, Minn., and professor of pathology, University of Minnesota.

November 20—Joint meeting with Diabetes Council. "Current Concepts of Diabetes," Dr. Francis D. W. Lukens, professor of medicine and director of the George S. Cox Medical Research Institute, University of Pennsylvania.

LUCAS

The Inter-Hospital Postgraduate Lecture Series, presented regularly by the Medical Advancement Trust of Maumee Valley Hospital, was scheduled to be held on October 4 and 5 in the headquarters building of the Academy of Medicine of Toledo, 3101 Collingwood Blvd., Toledo.

Two outstanding speakers are on the program. They are Dr. Kathleen E. Roberts, Department of Medicine, Memorial Center, New York City, and head of the Clinical Physiology Department at Sloan-Kettering Institute; and Dr. Parker

Vanamee, at present with the Rhode Island Hospital and Memorial Center and formerly with the Rockefeller Institute and the Army Chemical Center.

The program subject is "Electrolyte Alterations in Disease."

Encouraged by the enthusiasm with which last year's series was received, the Academy of Medicine of Toledo and Lucas County is sponsoring a series of public panel discussions this fall on the subject, "You and Your Health." The series of weekly programs began on September 20 and will continue each Thursday evening through October 11. The place is the Doermann Theater at the University of Toledo.

Dr. B. G. Shaffer, Academy president, announced the following panel members for the first of the series on the subject, "It's a Nervous World": Drs. John Stifel, Leslie Whitmire, Anne Robbins, J. B. Hirsch, Philip Stiff, William Thal and Robert Evers.

MIAMI

"Ophthalmology in General Practice" was the subject discussed by Dr. Robert Bruce, of Dayton, at the September 7 meeting of the Miami County Medical Society at the Stouder Hospital, Troy.

New members of the Society are Dr. Harry R. Hittner, West Milton; Dr. Mark F. Hance, Troy, and Dr. Glen S. Hogle, Troy.

MONTGOMERY

The Internal Medicine Section of the Montgomery County Medical Society held its meeting on September 26 with dinner at the Van Cleve Hotel. Speaker for the occasion was Dr. Johnson McGuire, professor of internal medicine at the University of Cincinnati whose subject was "Pericarditis."

PORTAGE

On the evening of September 5 at Ravenna, a combined dinner meeting of the Portage County Bar Association and the Portage County Medical Society was held. Twenty-six lawyers and 17 doctors became acquainted and discussed mutual problems. Dr. C. A. Gustafson, Sixth District Counselor, Youngstown, was guest speaker and gave an interesting and encouraging talk on the establishment of lawyer-doctor relationships. He cited the progress made in such matters in the Mahoning County area.

It was decided to hold a similar combined meeting at least each year.—Arthur L. Knight, M. D., Secretary-Treasurer.

PUTNAM

The Putnam County Medical Society held its first meeting following the summer recess on September 4. This meeting was favored by a

large attendance, nearly all members being present.

Following a dinner at Dumont Hotel, Ottawa, topics of general interest were discussed, and plans made for the scientific sessions to be held during the coming year.—H. N. Trumbull, M. D., Correspondent.

SANDUSKY

The first fall meeting of the Sandusky County Medical Society was held at Serwin's Restaurant. The program chairman, Dr. T. Stabholtz, presented as guest speaker Dr. Ernest Sternfeld, of Toledo.

SCIOTO

Dr. H. William Clatworthy, chief of the surgical service for Children's Hospital, Columbus, and associate professor of pediatric surgery, Ohio State University College of Medicine, was guest speaker at the September 10 meeting of the Scioto County Medical Society in Portsmouth. His subject was "Tumors in Childhood."

STARK

The Stark County Medical Society met at the Alliance Country Club on September 12 as guests of the Stark County Pharmaceutical Association. Dinner was followed by a talk by Mack Sauer, Leesville editor and humorist.

SUMMIT

Medical Director of the Akron Child Guidance Center, Dr. Louis D. Kacalief, was program speaker for the September 4 meeting of the Summit County Medical Society. His subject was "Discipline of Children."

What Every Physician Should Know About Contracts

"Ignorance of the law is no excuse" says the Columbus Better Business Bureau in an article consisting of questions and answers on contracts. The article points out that only general rules can be cited and that a lawyer should be consulted in specific instances.

Because physicians are called upon many times to sign contracts or, on the other hand, they may enter into agreements without written contracts—which they shouldn't—we believe the following excerpts from the BBB article are quite timely for the medical profession as a whole:

Is a contract always identified by a heading and the word "contract"?

ANSWER: No. Contracts or agreements need not be so identified. Contracts are sometimes represented as receipts, sales slips, guarantees, questionnaires, etc. Contracts may be oral or written. They may be made by correspondence and in many other ways. The law also recognizes "implied" contracts in certain circumstances.

Are you entitled to a copy of any contract which you sign?

ANSWER: Ethically yes, and most reputable



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concerns will give you a copy. You should make it a point to keep a copy of what you sign.

If one signs a contract without reading it, is it ordinarily binding?

ANSWER: Your signature on a contract indicates that you have read it and that you understand the terms and conditions. Furthermore, some contracts contain a provision to the effect that no representations other than those in the document itself should be recognized. Read before you sign.

How binding are contracts which read that no verbal representations are recognized?

ANSWER: The written contract usually holds, unless satisfactory proof is available you were induced to sign the contract through false or fraudulent representations. Any contract provision that specifically stipulates no consideration is to be given verbal statements, should serve as a warning signal to read the document again. Request all oral representations be inserted in the contract before you sign.

If you sign a contract simply to get rid of a persistent salesman, is it binding?

ANSWER: Yes, the written contract is evidence of your and his understanding and agreement. Your statement that you signed to get rid of the salesman is no justifiable excuse for breaking your agreement and promise.

Is a contract ordinarily binding when signed in blank and filled in later?

ANSWER: When you sign a blank contract, it means that you authorize the other party to fill in the terms. In a clear case of fraud, relief may be obtained through legal action. Have your contract filled in fully before you sign.

Does a guarantee mean satisfaction or your money back?

ANSWER: No, not unless the guarantee so states. The term "guaranteed" when used alone, means little and is ambiguous. Know the terms and limitations of the guarantee and the reputation of the guarantor before you purchase.

Are contracts signed on Sunday or holidays binding?

ANSWER: Yes, a binding contract may be signed on any day.

Rheumatic Disease Conference

Ohio physicians may be interested in attending the fourth annual Mid West Conference on Rheumatic Diseases, to be held October 10 at the Mellon Institute, Pittsburgh, Pa. Symposia on musculo-skeletal disorders and on rheumatoid arthritis are scheduled.

X-Ray Institute in Chicago

Ohioans in the field will be interested in an American Hospital Association-Sponsored institute for x-ray technicians to be held at the Shoreland Hotel in Chicago October 30, 31 and November 1.

INDEX TO ADVERTISERS

Abbott Laboratories	1022-1023
American Medical Education Foundation	1103
Ames Company, Inc.	1010
Ann Arbor School	1113
Appalachian Hall	1026
Atlas Pharmaceutical Laboratories	1089
Ayerst Laboratories, Inc.	1100
Baker Laboratories, Inc.	1011
Burroughs Wellcome & Co. (U.S.A.) Inc.	1027, 1106-1107
Chicago Medical Society	1116
Ciba Pharmaceutical Products, Inc.	1087
Coca-Cola Company	1026
Cook County Graduate School of Medicine	1099
Columbus Pharmacal Company	1101
Corn Products Sales Co. (Karo)	1030
Davies, Rose & Co., Ltd.	1093
Desitin Chemical Company	1031
Flint, Eaton & Company	1025
Foot-so-Port Shoe Company	1113
Geigy Pharmaceuticals, Inc.	1126
General Electric Company, X-Ray Dept.	1024
Harding Sanitarium	1021
Hoffmann-LaRoche, Inc.	Insert between pages 1020-1021
Knox, Chas. B., Gelatine Co., Inc.	1079
Lakeside Laboratories, Inc.	1005, 1099, 1116
Lederle Laboratories	1007, 1070-1071, 1119
Lilly, Eli, and Company	1036
Luzier's, Inc.	1097
Magnetic Springs Foundation	1130
Mallard, Inc.	1098
McMillen Sanitarium	1021
Medical Protective Company	1116
Merck Sharp & Dohme	1028-1029, 1121
New York Polyclinic Medical School	1120
Ohio Academy of General Practice	1095
Parke, Davis & Company	1032-1033, 1132 and Inside Back Cover
Pfizer, Chas. & Co., Inc.	1110-1111, 1117, 1131
Picker X-Ray Corporation	1124
Quincy X-Ray & Radium Lab.	1097
Riker Laboratories, Inc.	1125
Rocky Glen Sanatorium	1130
Sanborn Company	1127
Sawyer Sanatorium	1020
Schering Corporation	1012-1013, 1018-1019, 1034-1035
Scroggins, Clayton L., Associates (Medical-Dental Management)	1193
Searle, G. D. & Company	1085
Smith, Kline & French Laboratories	Back Cover
Seuibb, E. R. & Sons, Division of Olin-Mathieson Chemical Corporation	1118
Stoneman Press	1120
Tutag, S. J. & Company	1089
Upjohn Company	1128
U. S. Vitamin Corporation	1122-1123
Wallace Laboratories	1075
Wendt-Bristol Company	1116
Wickhaven Sanitarium	1115
Windsor Hospital, Inc.	1130
Winthrop Laboratories	1017, 1095
Wyeth, Inc.	1009, 1105, 1109, 1129
Year Book Publishers, Inc.	1015

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The Physician's Bookshelf

By JONATHAN FORMAN, M. D.

How to Free Yourself from Nervous Tension, by Samuel W. Gutwirth, M. D., (\$3.95. *Regnery Press, Chicago 4, Ill.*). The author is one of the students of the famous psychologist Dr. Edmund Jacobson, who spent his life in research into the subject of relaxation. He is also one of his patients, who was stricken with a crippling disease many years ago, and is now among the one-half of one per cent of people still alive who have had this crippling disability. He gives aids to the art of relaxation which he learned from his master. The book is written in the spirit of complete dedication. The author is convinced by his own struggles that all men can live happier and better lives by the application of the principles of relaxation.

Surgical Physiology of the Adrenal Cortex, by James D. Hardy, M.D., (\$5.75. *Charles C. Thomas, Publisher, Springfield, Ill.*). Written primarily for surgeons, this book considers the physiology and management of most of the complications and lesions with which the surgeon must deal.

From Witchcraft to Antisepsis, by Douglas Guthrie, (\$1.50. *University of Kansas Press, Lawrence, Kansas*). This is the fifth series of the Logan Clendening Lectures on the History and Philosophy of Medicine. The author is the Lecturer on the History of Medicine, in the University of Edinburgh. The theme of each of the two lectures is the very antithesis of the other, but from each we learn something of whence we came and this helps to explain where we are. Magic has always had an important place in our Art. In his lecture on antisepsis, Guthrie re-emphasizes the principle which we are so apt to loose sight of, namely that the sudden revelation of an important fact to a mind ready to grasp its significance is the essence of most discoveries in medicine.

Galen of Pergamon, by George Sarton, (\$2.50. *University of Kansas Press, Lawrence, Kansas*). These are the 1954 series of Logan Clendening Lectures on Medical History and Philosophy by the Dean of the Historians of Science. He gives us a sketch of the life of Galen—his career and personality as well as an appraisal of his relation to his times and to the general history of medical knowledge.

Science, Religion, and Reality, edited by Joseph Needham, with introductory essay by George Sarton, the historian of Science, (\$3.95. *George Braziller Inc., 215 Fourth Ave., New York 3, New York*). This is a reprint of the essays first published in 1925, which have attained the dignity of a classic, but which have been unobtainable until the appearance of this issue. It emphasizes

that the conflict here is triangular—between reality on the one hand, and its two shadows, science, and religion. This may come as a shock to some of us who look upon science as a reality. If one stops to think of it, the scientist operates on many more assumptions than does the theologian. The theologian's basic assumptions are few in number, while science is a continuing recurrence of assumptions. This classic makes a great contribution to living. Everyone must try to answer the fundamental questions of life; nobody can do it perfectly, but everybody should do his best.

The Fields of Group Psychotherapy, edited by S. R. Slavson, (\$6.00. *International Universities Press, Inc., New York 11, N. Y.*). Group Psychotherapy arrived on the scene without labor pains. It was met with singular receptivity not only from professors and their pupils but from the general public as well. It has met with favorable response from the intelligent man on the street and from the Press. Many give testimony as to its acceptability. This book is the result of the cooperation of the American Group Psychotherapy Association.

I Had Heart Disease, by Henry Perry, (\$2.00. *Pageant Press Inc., New York 36, N. Y.*). Thirty-five years ago the author was condemned to die because of heart disease. Instead of giving up, he entered the practice of law in Marion, Indiana. Later he entered the hotel business, where he worked night and day in a building having more than one floor but no elevator. The diagnosis of valvular heart disease seems well established, because every doctor who listened to his heart made this diagnosis, and he was refused for the army on account of it.

The Value of Hypnosis, by Paul Schilder, translated by Greda Corvin, (\$4.00. *International Universities Press Inc., New York, N. Y.*). The original German monograph goes back to 1921. This is essentially a re-issue of a book long out of print.

Gynecology, edited by Robert J. Lowrie, M. D., with foreword by J. P. Greenhill, M. D., (\$17.75. *Charles C. Thomas, Publisher, Springfield, Ill.*). Fifty-eight contributors from the English speaking world present here the current teaching and research in the great medical schools throughout this part of the world. Many of the chapters would well make a monograph by themselves.

Office Procedures, by Paul Williamson, M. D., (\$12.50. *W. B. Saunders Co., Philadelphia 5, Pa.*). Detailed instruction covering all office procedures are given in this book. Often suggestions are
(Continued on Page 1154)

"In 96 per cent (24 patients) clinical symptoms were relieved and the blood pressure maintained at comfortable levels. . . ."¹

Philadelphia 1, Pa.

- ert, A., and Albert, M.: Am. Pract. &
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made to use homemade equipment or the materials at hand, recognizing of course, that it is better to use instruments designed for the specific job, but when they are not immediately available, the suggestions here become extremely valuable.

The Therapy of Skin Tuberculosis, by Gustav Riehl, M. D., and Oswald Kopf, M. D., translated and revised by Ernest A. Strakosch, M. D., (\$6.75. *Charles C. Thomas, Publisher, Springfield, Ill.*). Written for skin specialists and to stimulate interest in the field of tuberculosis, this book is concerned mainly with the clinical value of Vitamin D-2 in the treatment of skin tuberculosis. Also discussed is the use of antibiotics, para-aminosalicylic acid, combination chemotherapy, tuberculin therapy, physical methods, and the use of isonicotinic acid hydrazide.

Psychotherapy in Some Surgical Conditions, by Joan E. Cash, (\$5.00. *J. B. Lippincott, Philadelphia, Pa.*). This book tries to show how psychotherapy is of value in some of the diseases and injuries treated by surgeons. There are 343 pages of detailed information on these various conditions, making this an extremely worthwhile manual in its field.

Problems in Amoebiasis, by Charles W. Rees, Ph. D., (\$4.75. *Charles C. Thomas, Publisher, Springfield, Ill.*). An evaluation of the presently held concept of the role of *Endamoeba histolytica* and the probable participation of the intestinal bacteria in the etiology of this disease, with descriptions of methods of approach to these problems. The emphasis is upon techniques, but there is much practical information on such matters as the incidence of the disease, the nutritional factors, the problems of diagnosis, and experimental chemotherapy.

Androgens; Biochemistry, Physiology, and Chemical Significance, by Ralph L. Dorfman, Ph. D., and Reginald A. Shipley, of Western Reserve University, (\$13.50. *John Wiley and Sons, New York 16, N. Y.*). It is now approximately 25 years since concentrated extracts of these substances were first prepared from testicular tissue. In the meantime much has been learned and the androgens have become definite, important therapeutic agents. This book is designed both for the general practitioner and for the specialists. Androgens, by virtue of their different roles in normal physiology, must be considered by any medical specialist—the internist, the endocrinologist, the pediatrician, the urologist, the gynecologist, the gerontologist and the oncologist. The theoretical and practical aspects are documented in a book of 575 pages.

Group Processes, Transactions of the First Conference, Ithaca, New York. Edited by Bertram Shaffner, M. D., sponsored by and published for Josiah Macy Jr., Foundation, New York, N. Y. (\$5.50.) This deals with ontogeny and living systems, psychology and ethology, morphology of

behavior, the dynamics of mother-newborn relationships in goats, the perception of animal behavior and group processes in lower vertebrates.

Principles of Psychoanalysis, Their Application to the Neuroses, by Herman Nunberg, M. D., with foreword by Sigmund Freud, (\$7.50. *International Universities Press, New York 11, N. Y.*). This is a long overdue translation of a fundamental text, which, for its English edition, has been greatly enlarged.

The Mysteries, Papers from Eranos Yearbooks No. 2, edited by Joseph Campbell, (\$5.00. *Pantheon Books, New York, N. Y.*). These papers were selected from the Yearbooks and published in the Bollingen Series XXX-vol. 2. Eranos is a gathering of individuals from Germany who meet once in a year in Switzerland and announce a theme for each meeting. The contributors are historians, anthropologists, theologians, and philosophers. While there was great contrast in viewpoint, there was equally evident the common context of human aspiration and realization.

Personal Health Measures and Immunization, Vol. III of the series, Preventive Medicine in World II, Editor-in-chief, Col. John B. Coates, Jr., (\$3.25. *Office of the Surgeon General of the U. S. Army, Washington 25, D. C.*). This presents the more important personal health considerations which influenced the sum total and day-to-day life and experience of officers and men of the army. Personal hygiene, immunization, food and nutrition, prevention of injuries, preventive psychiatry—these are only a few of the aspects of preventive medicine which are here discussed.

Vascular Surgery in World War II, edited by Daniel C. Elkin, M. D., and Michael De Bakey, M. D., (\$4.50. *Office of the Surgeon General of the U. S. Army, Washington 25, D. C.*). This treatise on vascular surgery is among the third series of medical history of the war to receive publication. It presents convincing testimony to the great progress in the field of which it treats. The simplest form of ligation is one of the oldest forms of military practice, but in its modern treatment, it is revolutionary.

Pharmacology in Nursing, by Elsie Krug, R. N., M. A., and Hugh McGuigan, M. D., (\$4.75, 41 text illustrations, 8 color plates, 7th edition, *C. V. Mosby Company, St. Louis 3, Mo.*). This standard text has been brought up to date in accordance with the changes in the pharmacopeia in the United States of America and the National Formulary, 10th edition. It mentions some pertinent new drugs which have been accepted by the American Medical Association.

Faith, Reason and Modern Psychiatry, Sources for a Synthesis, edited by F. J. Braceland, M. D., and eleven other contributors, (\$6.00. *P. J. Kenedy and Sons, New York 7, N. Y.*). This is a symposium warning against the neglect of psychiatry and mental hygiene instruction in this

country. The psychiatrist, the authors say, meets little opposition from philosophers and theologians when dealing with psychiatric problems. It is when treating neuroses by psychotherapy that they run afoul of the critics. The editor feels that the psychiatrists often designate as the ideal goal of their therapeutic efforts to balance the burden of moral responsibility by simply the achievement of social adaptability under the mask of anti-authoritarianism.

The Treatment of Eczema in Infants and Children, by Lewis Webb Hill, M.D., (\$4.00. C. V. Mosby Company, St. Louis, Mo.). This is a series of readable, practical articles which appeared originally in the *Journal of Pediatrics*. Nothing better has ever appeared in this field. It certainly should be in every Intern Working Library and on the desk of physicians who see these little sufferers.

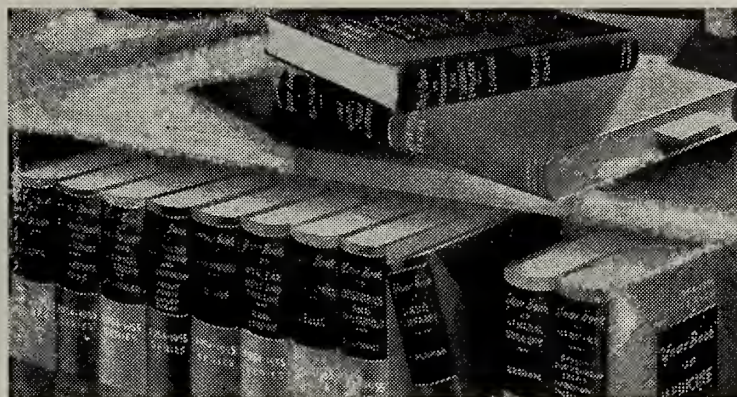
Lectures on the Scientific Basis of Medicine; Volume Three, 1953-54. (\$6.00. University of London, The Athlone Press, United States distributor: John de Graff, Inc., New York 10, New York). The aim of these lectures given each year under the auspices of the British Postgraduate Medical Federation is to present an integrated, continuously developing survey of current scientific research in its relation to clinical medicine. In this volume there are 21 lectures reflecting the growing knowledge of the chemical and physical structure of biological tissues, of how they are built up, how they react to injury and how their interdependence contributes to the health of the individual.

Modern Nutrition in Health and Disease, edited by Michael G. Wohl, M.D., and Robert S. Goodhart, M.D., with 53 contributors. (\$18.50. Lea and Febiger, Philadelphia 6, Pa.). Wherever a diet is a factor in the treatment of disease or in the maintenance of good health, this complete work by 55 foremost American authorities, makes one of the best sources for reference. An important feature of the work is the physiological approach, the recognition of nutrition as an essential part of the management of a sick person, and not as an isolated therapeutic tool.

The Problem of Onanism, by Baron Frederick Von Gager, M.D., Translated from the German by Meyerick Booth, Ph.D. (\$2.50. The Newman Press, Westminster, Maryland.) An excellent discussion of the subject from the viewpoint of psychology and neurosis.

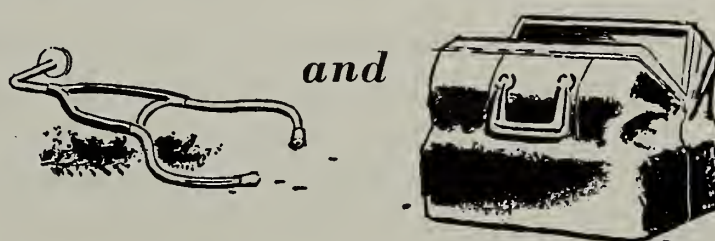
Love and Love's Philosophy, by Henri Birnbaum, M.D. (\$3.50. Pageant Press, New York 36, New York.) This is a contribution to the biology of the personality and a definitive work. It is a charming essay on all aspects of the subject. It is a unique book; only a philosopher could have conceived it.

for November, 1956



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The Ohio State Medical Journal

Published under the direction of The Council for and by the members of The Ohio State Medical Association, a scientific society, non-profit organization, with a definite membership, for scientific and educational purposes.

Vol. 52

November, 1956

No. 11

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Rational Treatment of Diabetes

HENRY J. JOHN, M. D.

IN the treatment of any condition the ideal is and must be to return the patient to as near normal physiological condition as possible. Only when we have accomplished this, have we reached our goal and given the patient that which he is entitled to and for which he sought our help.

The treatment of diabetes is no exception to this. Here especially it is important to return the patient's aberrant physiology to normal physiology so that he can avoid the many degenerative complications which usually occur some years after the onset of the disease, such as: retinal hemorrhages, arteriosclerosis, neuritis, intercapillary glomerulosclerosis, acidosis and coma. Here there is a great field for preventive medicine, namely to try to prevent complications.

In order to accomplish this, we must first of all prevent long-standing hyperglycemia which tends to augment the complications mentioned. The evidence for this is that in uncontrolled diabetes we get more of these complications than we do in those who are well controlled.

There is such a thing as postprandial hyperglycemia even in non-diabetics, which is normal. Such a hyperglycemia follows each meal, but the blood sugar usually does not rise to a very high level and comes back to normal quickly; usually in one and a half to two hours; so that if we check the non-diabetic patient just before lunch, the blood sugar will be normal, or, as we say, "the blood stream has cleared itself of excess of sugar" before the next meal. The same applies to the blood sugar before dinner. In other

The Author

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words, checking a non-diabetic individual three times a day, just before each meal, provided there has been no food intake between meals, we will find a normal blood sugar level. See Chart 1.

Such is not the case in a diabetic. His fasting blood sugar may be normal just before breakfast, but the noon and the evening blood sugar will be elevated. See Chart 1. (These data are taken from actual examinations.) Were we to take only the fasting blood sugar in the case in Chart 1, the upper curve, which is normal, we would have missed completely the elevated noon and evening blood sugars and would have given wrong advice, wrong diagnosis to the patient who, continuing on the same routine would have inevitably shown an elevated morning blood sugar in time. A great deal of ground would have been lost.

Or, the patient may have all three blood sugars high as one can see from the subsequent Charts 2-5, as noted from the data of the examinations on the first day. In all these the administration of insulin is indicated. There is no need of trying to straighten out the diabetic patient's condition on reduced diet alone which

takes time, and where in most cases we have to resort in the end to insulin. In this manner much useless work had been done and much time lost.

OFFICE TREATMENT

I always keep the patient in the office after the third blood sugar (pre-dinner) is read, then if elevated I administer insulin immediately. For a few subsequent mornings the patient comes to the office without breakfast for the fasting blood sugar check. The drop or the lack of drop of the fasting blood sugar tells me whether to increase or to decrease the dosage. This you will note in the following charts. When the fasting blood sugar reaches the normal level and there are no reactions, that is a presumptive evidence that the overall dosage is about correct. (With patients who go to work early in the morning and finish at 3:30 p.m., I use the 4:00 p.m. blood sugar for this same information.)

The patient continues on such a dosage for a week or two and then is rechecked three times daily, before meals, so that we can be sure that not only the fasting blood sugar is normal, but that the blood sugars throughout the day are also normal. See Chart 1, the lower curve, where that same diabetic patient presented all three normal blood sugars before each meal after only a few days on insulin. If all three blood sugars are normal then we have reached our goal, for we have returned the diabetic patient to normal physiology by making up his insulin deficit with proper dosage of exogenous insulin, sufficient to return the blood sugar to a normal level within

the same time that it takes for a non-diabetic's blood sugar to return to normal.

The next problem to watch: does he, after a few weeks or months begin to have insulin reactions? If he does, this indicates that the pancreas is functioning better, secreting more insulin, and that we can now start reducing the insulin dosage. This, however, should be done only after a complete recheck, three times a day, before meals, so that we can be sure of a proper procedure.

I am stressing the use of the term "insulin reaction" for the following reason: unfortunately many medical men speak of an insulin reaction as "insulin shock." This, psychologically, is a very bad term. There is such a thing as an insulin reaction and there is such a thing as "insulin shock," but these are two very different matters. Unfortunately the new patient has been hearing about the "insulin shock" treatment for mental cases, and he is scared to death of it and he will invariably say: "Doctor, I'll do anything just so I don't have to take insulin."

What is an insulin reaction? We do not know exactly what it is, but we do know that usually it is accompanied by a low blood sugar which in turn means that too much exogenous insulin had been used for the patient's needs at that time. However, in general, hypoglycemia is present at the time of an insulin reaction. I have also seen reactions when the blood sugar at the time of the insulin reaction was as high as 254 mg. per 100 ml. On the other hand, not all hypoglycemiae are accompanied by the symptoms of an insulin

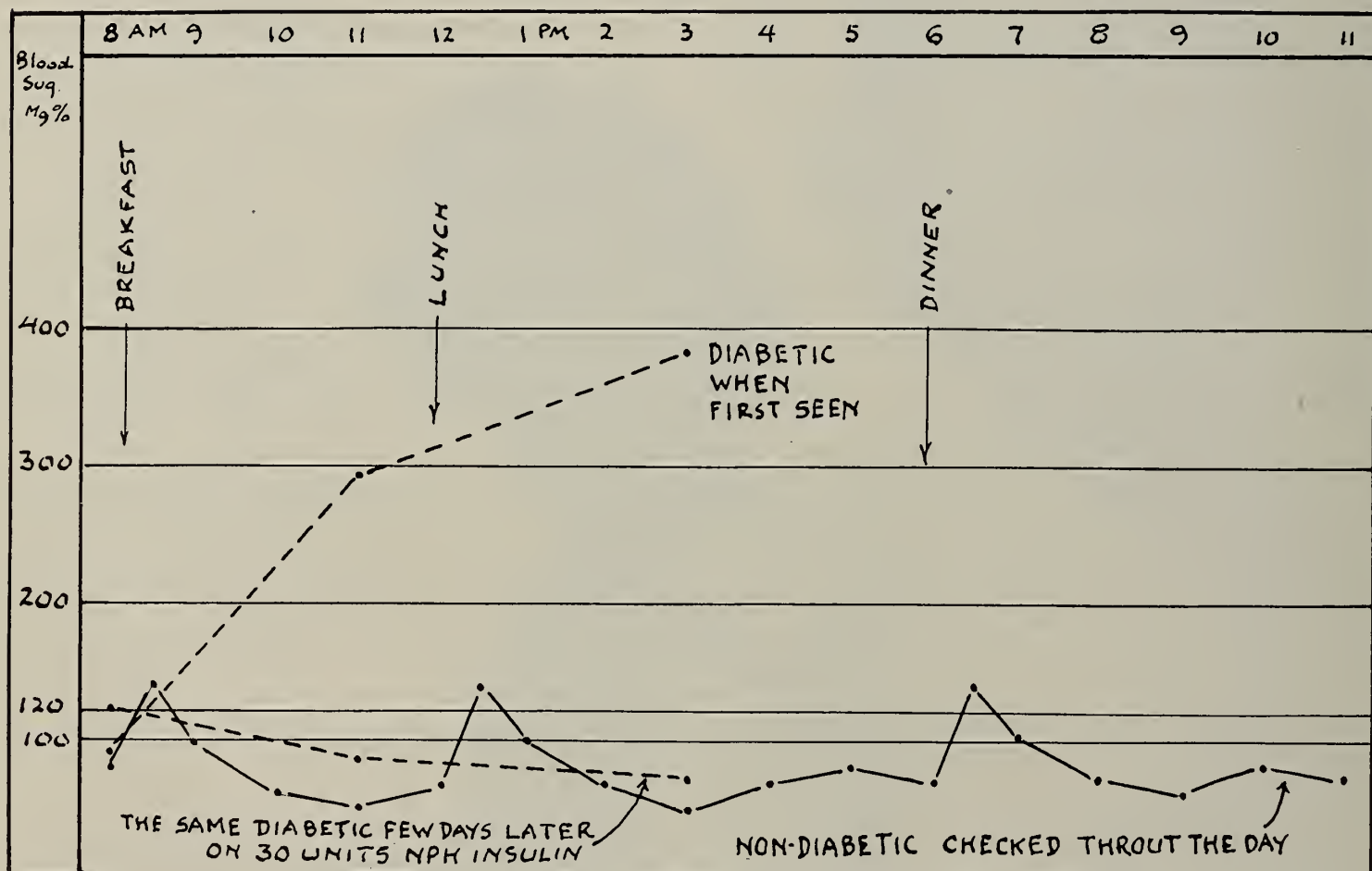


CHART 1

reaction for I see frequently hypoglycemias as low as 32, 28, 34 mg. per 100 ml. when the patient does not experience any insulin reaction, feels well and is not conscious of the low blood sugar.

To treat an insulin reaction one needs to take some carbohydrate in any form which usually allays the disturbing symptoms that accompany a reaction. I usually ask my patients to keep a can of Karo syrup in the refrigerator and in case of an insulin reaction, to take a tablespoonful. If the patient is deep under and cannot open his mouth, I have instructed the members of the family to rub some of the syrup on his gums and inside the cheeks. If he does not come out of the reaction in 10 minutes, then take 2 tablespoonfuls of the Karo syrup in three-fourths of a glass of quite warm water and give it as a very slow enema. This works well especially in children and soon the parents lose any fear of an insulin reaction, for I have always impressed on them that insulin reactions are not dangerous, but merely undesirable; that an insulin reaction is a patient's problem and not a doctor's problem to handle.

WHAT TYPE OF INSULIN SHOULD ONE USE?

We now have several types of insulin on the market:

1. *Insulin*, the original, clear, quick acting insulin, the action of which usually wears out in a few hours.

2. *Protamine zinc insulin*, which is a slow acting insulin and whose action is not evident for about 3 hours after the injection but lasts over a long period of time. If given in the morning it will act until next morning.

3. *Globin insulin*, whose action is fairly quick after injection and lasts for about 18 hours. Thus this type of insulin, taken in the morning, is not apt to bring on an insulin reaction during the night or towards morning.

4. *NPH insulin*, whose action is fairly prompt and when given in the morning, it lasts until next morning. This type of insulin acts much like the combination of 1 and 2 and for that reason it is the most practical insulin to use.

5. *Insulin lente*, which acts much like No. 4. It is supposed to be a more purified product and does not contain any protamine.

Thus in summary: If we want a quick action we use insulin No. 1. Because of its slow action at the start, No. 2, the protamine zinc insulin frequently does not protect the patient from the post-breakfast hyperglycemia, in which case we have to add insulin No. 1, to take care of the breakfast. This, of course, must be properly evaluated by checking the blood sugar three times a day, before meals. The globin insulin, No. 3, I often use in older people and cardiacs to prevent insulin reaction during the night or towards

morning. The NPH insulin, No. 4, is the most logical insulin to use as it combines the principles of PZI (protamine zinc insulin) plus insulin. The insulin lente, No. 5, works much the same as NPH insulin for those who prefer to use it.

Most of these insulins are extracts from beef or pork or a combination of the two. At times a patient may have a local reaction to one or the other type. When this happens, we must use a "special insulin" which is made up by the pharmaceutical company for the patients according to their allergies. These special insulins are not on the market. In my own practice I have rarely seen an allergic reaction to the commercially produced insulins mentioned above.

These insulins come in various concentrations: U-10, U-20, U-40, U-80, U-100. This is most unfortunate and causes many errors if the patient gets the wrong concentration or uses the wrong scale on the syringe. This confusion happens even to nurses giving carefully prescribed insulin dosages in hospital. I never use anything but the U-80 concentration as that is the most logical one. It causes the least amount of discomfort to the patient, since the bulk of the injected fluid is reduced to the minimum. With it, of course, one uses U-80 scale syringe. One must also bear in mind that only the insulin No. 1, can be used intravenously.

THE SYRINGE

For the past few years we have been using a one-scale syringe. This eliminates mistakes. A syringe with both the U-40 and U-80 scale on it leads often to errors and the patient may get either twice as much or one-half as much of the insulin he is supposed to get. That was the reason for introducing the single scale syringe and one should always buy the one-scale syringe. If one uses U-80 insulin, one uses the syringe with U-80 scale on it.

Even the blind can now give themselves insulin. There has been on the market for many years a special type of insulin syringe for the blind (the B & D Improved Cornwell syringe, No. 1250). Here the physician sets the gauge for any dose desired and the blind patient learns to use it automatically.

There is also another useful gadget on the market, an enlarging glass which makes the reading on the syringe scale easy for those who do not see well. It just clamps down on the syringe. A Cleveland nurse developed it and it can be procured from her (Marion E. Tschischeck, R. N., 1206 Sunset Rd., Mayfield Heights, Ohio).

THE DIET

When insulin became the standard therapy for diabetes, the once rigidly low caloric diets of diabetic patients were increased so that today their diets are virtually the same as those of non-diabetics. Before the insulin era, because of the low calories, food had to be weighed or measured

in order to keep the low caloric values accurate. Now, with liberalized diets, we no longer have that same problem.

For the past eight years, I have advised this: No sugar, no pastry (pie, cake, cookies), candy, no soft drinks (such as ginger ale, Coca-Cola, root beer, pop and beer), and no milk for adults. A maximum of six slices of bread daily; when a small potato is taken at a meal then no bread should be eaten. I have had adult patients come to me who had been using as much as 3 quarts of milk a day, just because they were thirsty, not realizing that besides the other food values, milk is a 5 per cent carbohydrate, thus yielding in 3 quarts 150 grams of sugar in addition to its protein and fat calories. In children, of course, I insist on one quart of milk a day.

By eliminating the high carbohydrate foods as mentioned in the foregoing, one automatically reduces the patient's carbohydrate as well as caloric intake. Next I tell them to eat whatever is on the table, only to eat in moderation, no two or three helpings and to watch their weight. If they gain weight they are to reduce the amount of food consumption.

Such a simple routine has worked admirably. It makes possible the working out of their problem without the abnormal routine of hospitalization. It develops more normal and healthier attitudes in patients by not setting them off from the rest of the family as "poor diabetics." The psychological factor here is a potent one. It makes the diabetic feel at ease, not abused by fate and therefore more cooperative in the proper control of his blood sugar. The main point is, that it works! A good principle to put before a diabetic is that it is not so much what he eats but how much he eats which is important. Charts 2-5 show how well such a routine has worked.

Often a doctor tells the diabetic patient all the things he cannot have. This is bad psychology. A better approach is to tell him all the things he can have so that he is not scared to death right at the start and eliminate the feeling that his diet is something different from that which the family eats, that he is "set apart" so to speak from the rest of mankind.

URINE SUGAR

The first thing to remember about glycosuria is the fact that it does not run parallel with the blood sugar level in most instances. The second thing to consider is the fact that if the urine is concentrated, i. e. of small volume, it is apt to show considerable sugar; on the other hand, if the volume is large, it may show only a faint trace or a trace of sugar, whereas the actual amount of sugar may be exactly the same in both specimens. To give additional insulin if the sugar in the urine is found at any special time of the day, therefore is not correct because of the foregoing factors.

I frequently find a heavy glycosuria during the

day when the blood sugar, taken at the same time, is 32, 34, 28 mg. per 100 ml. To give such a patient, be he a child or an adult, extra insulin at such time (and it is being done frequently), often throws him into a severe insulin reaction. In such case one then has to give extra carbohydrate to counteract the reaction which then tends to upset the whole routine. It is the blood sugar level which is important, not the urine sugar, for only the blood sugar gives an accurate gauge to the insulin dosage. If the three blood sugars during the day are normal, then it does not matter whether or not glycosuria is present.

It has been said that figures such as I just gave, are but a rare exception to the general rule. This is not so. Anyone who takes the trouble to follow out the three times a day, before meals, blood sugars and the urine examinations at the same time, will soon be convinced how frequently this happens; that it is the rule rather than the exception. Such contrary statements are purely speculative and are based not on facts or on laboratory findings done in a systematic manner.

Estimation of the 24 hour, quantitative urine sugar is of considerable value, for it tells us how many grams of sugar that patient is excreting which, in turn, tells us what he is utilizing from his daily food intake. Such excretion should not exceed 10 grams urine sugar per 24 hours which is permissible. If more than 10 grams is excreted then a change in the diet-insulin routine is indicated.

Another thing of value is to test the urine for acetone to make sure there is no ketonuria, namely acidosis. The test now is very simple with the acetest® tablets manufactured by Ames Company, Inc. (One drop of urine placed on a tablet tells the story. If no acetone is present, the tablet stays white. If heavy acetone, it will turn purple.) This test takes only about two minutes.

HOW TO MAKE A DIAGNOSIS OF DIABETES

Any new case, where glycosuria is discovered on routine examination, should be checked immediately in order to find out whether such a glycosuria is a non-diabetic glycosuria or glycosuria due to diabetes. If diabetes is ruled out, no attention needs to be paid to the glycosuria since there is no treatment for it and it does no harm.

I usually do this: Patient comes in at 8 a. m. without breakfast and I check his blood and urine sugar. He has then immediately a normal breakfast. Then he is rechecked 3 hours after breakfast. If both blood sugars are normal, then I have him take a very heavy carbohydrate lunch and recheck 2.5 hours from the time he started eating. If this last blood sugar is normal, this rules out diabetes. On the other hand, if that patient is even a mild or borderline diabetic, the last blood sugar will be elevated and the

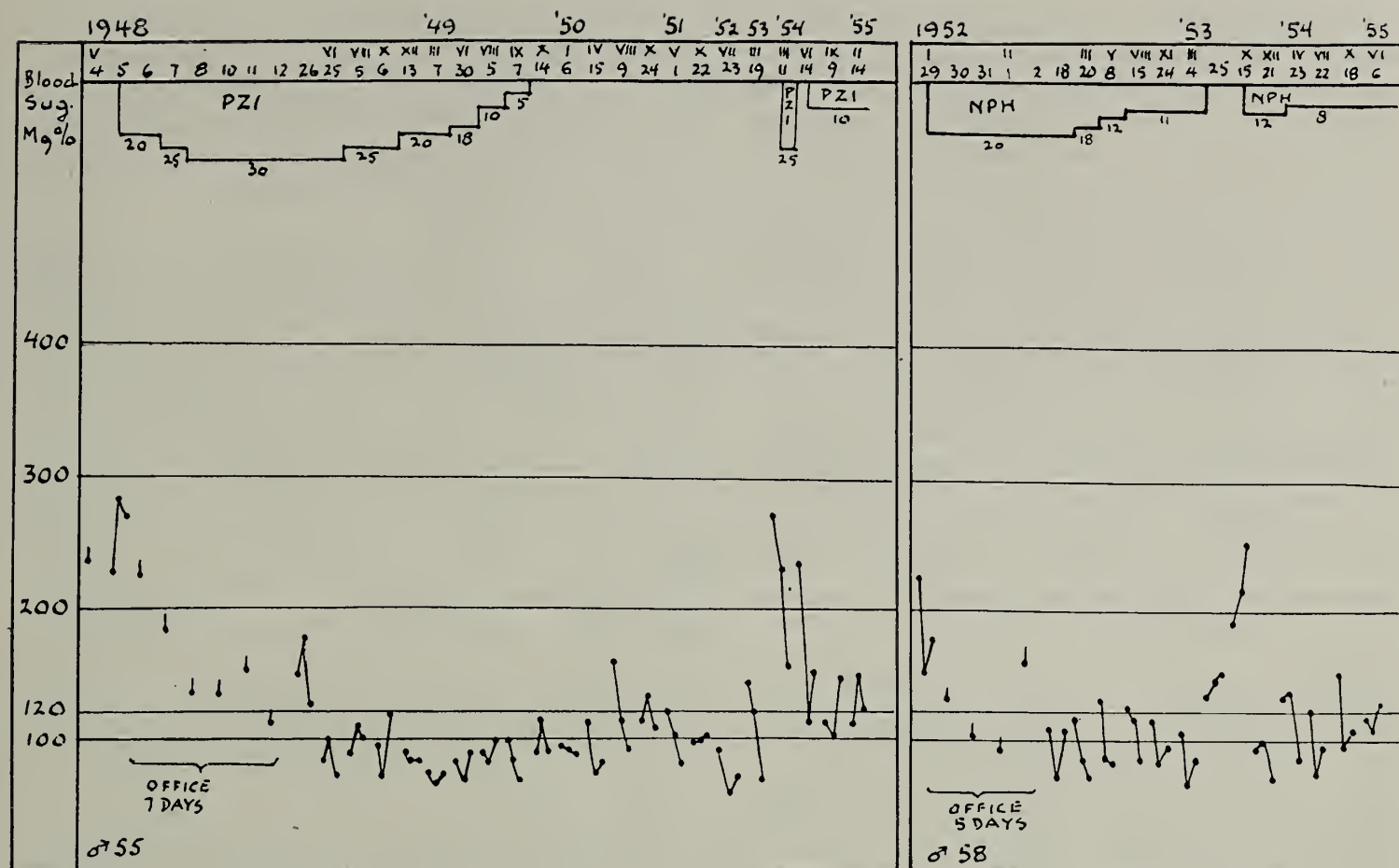


CHART 2

diagnosis of diabetes established. However, if the morning or the noon blood sugar is high, then we already know that the patient is diabetic and there is no need to subject him to a glucose tolerance test for it will not tell us any more than what we already know.

THE USE OF GRAPHIC CHARTS

The keeping of graphic charts on diabetic patients is extremely valuable. In this manner one grasps at a glance what is happening, just as one glance at a temperature chart tells what type of fever the patient is having—whether the curves are typical of typhoid fever, or pneumonia et cetera.

On diabetic patients one charts the blood sugar level, the urine sugar, insulin dosage, albumin in the urine, acetoneuria, weight, blood pressure, etc., at each checkup and one adds any other type of information one may have gained, such as surgery, infections, etc. In this manner, on any subsequent examination, one sees the whole story at a glance and can correlate the present findings with those that preceded, often over many years. I have kept such records for over 31 years and it is remarkable how much help they are in the evaluation of the patient's status at any given time. It is well worth the time it takes to keep such records systematically for the control of diabetes is a systematic, scientifically rational procedure.

SUMMARY

I have outlined the routine procedures in the treatment of diabetes that I have been using for

the past 30 years and the reasons for each step. I have also stressed the necessity for adequate laboratory information which is so necessary for the proper interpretation of the findings which insures proper dosage of insulin at the time. It is necessary to know the normal physiological response of the body, the blood sugar level following the three meals a day, in order to correlate the response of the diabetic patient to that same routine. The great necessity here is the taking of the 3 blood sugars a day—three times a day, after meals—so that one is not misled. (See Chart 1.)

The type of insulin to use is discussed and the varying action of each. The high concentration of insulin, U-80, is stressed for the sake of making the minimum distress for the patient. Also the necessity of using the one-scale syringe in order to eliminate mistakes in the dosage.

The urine sugar is discussed at length so that proper interpretation can be made in this respect. The use of graphic charts on diabetic patients is discussed, and, at the end, a series of charts on the progress of diabetic patients on liberalized diets is given which illustrate their progress.

PROGRESS OF PATIENTS AS INDICATED IN CHARTS 2-5

Chart 2. The first patient, the record on the left, was first seen in 1948, at which time he had considerable elevation of blood sugar throughout the day. Observations on this patient extend over a period of eight years. He came to see me because glycosuria had been found on

routine examination, and the blood sugar the day before I saw him was 236 mg. per 100 ml. He had all the classical symptoms of diabetes. His brother and sister died of diabetes, some time previously. The rest of his history is unimportant.

My first day's blood sugars, on May 5, 1948, were 227 - 285 - 272 and he showed a heavy glycosuria throughout. There was no albumin in the urine, but 3 plus acetone. Thus that same day, after the last blood sugar, I gave him 20 units of protamine zinc insulin and he came daily to the office, in the morning, without breakfast. Note the drop in the fasting blood sugar to normal on the fifth day. He was regulated on 30 units of PZI insulin and he was rechecked two weeks later on May 26 and the blood sugars were not far from normal. Recheck a month later when all three blood sugars were now normal on liberalized diet.

During all this time he was carrying on his business activities. As time went on, under perfect control, the insulin was reduced and finally on Sept. 7, 1949, thus in 13 months, all insulin was discontinued. He did well without insulin for 3.5 years. Then, as it occasionally happens, he got a bit careless in his diet and when rechecked March 11, 1954, all three blood sugars were elevated and insulin had to be resumed. Again the blood sugars came down to normal in six months' time and he is well controlled on but 10 units PZI a day.

This sort of thing happens now and then when a patient is perfectly controlled and stays controlled on diet alone, he begins to feel that he

no longer has diabetes and he gets careless. Note that in 1952, 1953, he came to be checked up only once a year. The periodic checkup, once every three months, after a patient is straightened out is quite important as it gives us an opportunity to step in on time to prevent the downward progress of diabetes.

Chart 2. The second patient, the record on the right, is a male 58 years of age who came with the history that glycosuria had been found two weeks previously. He has had nocturia 2x for three months. His father had diabetes. The patient had rheumatism in childhood, jaundice at age 12, heart attack October 1951.

On the first day, Jan. 29, 1952, his blood sugars were: 222 - 150 - 176 and there was glycosuria throughout. That same evening I gave him 20 units NPH insulin and the subsequent fasting blood sugars came to normal on the third day, showed a slight elevation on the fourth. He kept on taking 20 units NPH insulin each morning, and the control was perfect for the next 10 months, even with the reduction of insulin dosage to 11 units.

On March 4, 1953, all insulin was discontinued but I rechecked him three weeks later to make sure he could manage without insulin. All three blood sugars were elevated and he was returned to taking 12 units NPH insulin each morning. This was reduced to 8 units two months later on which dosage he is now well controlled on liberalized diet, carrying on his business as usual during all this time.

Chart 3. (Case on the left): Man, 51 years

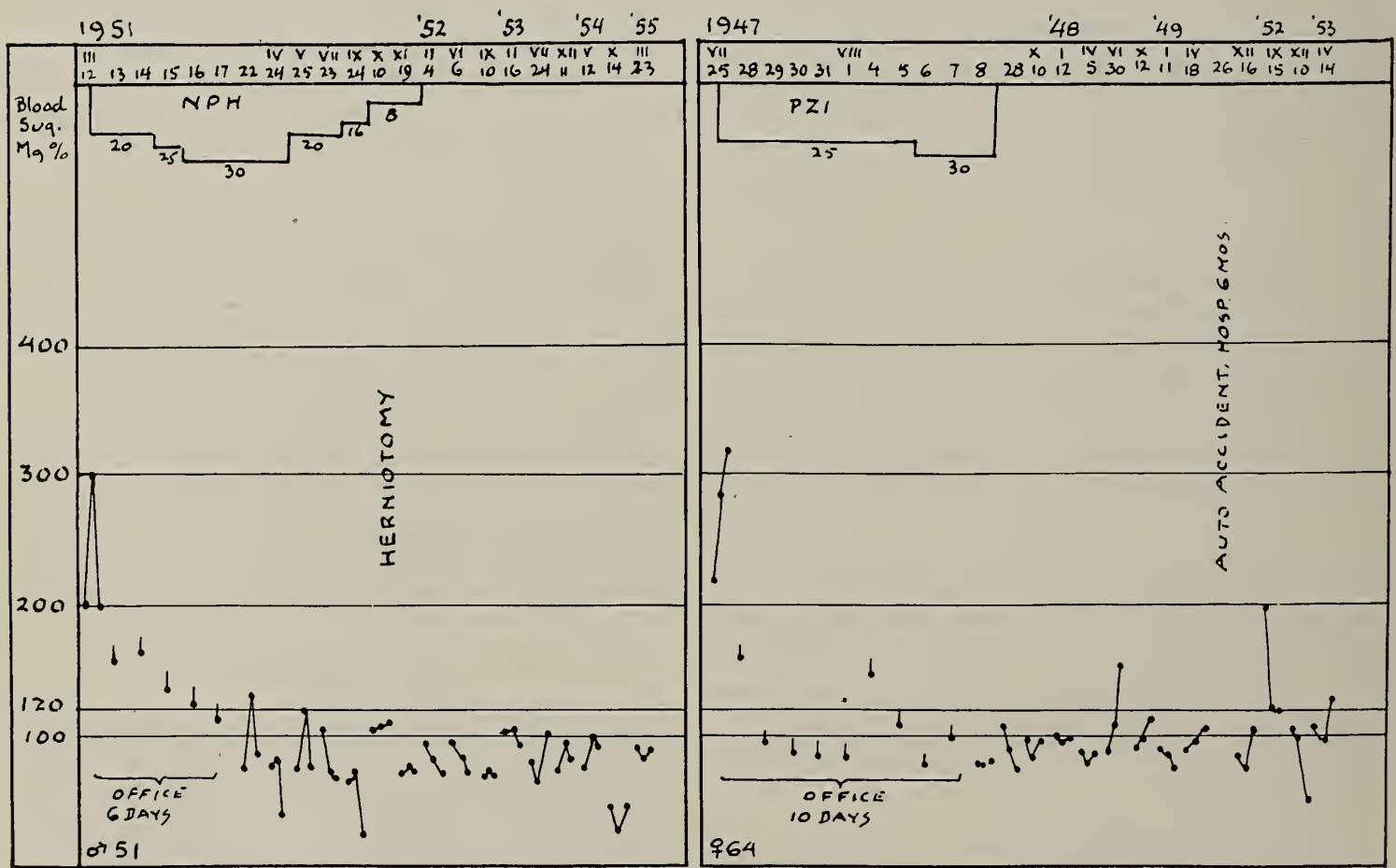


CHART 3

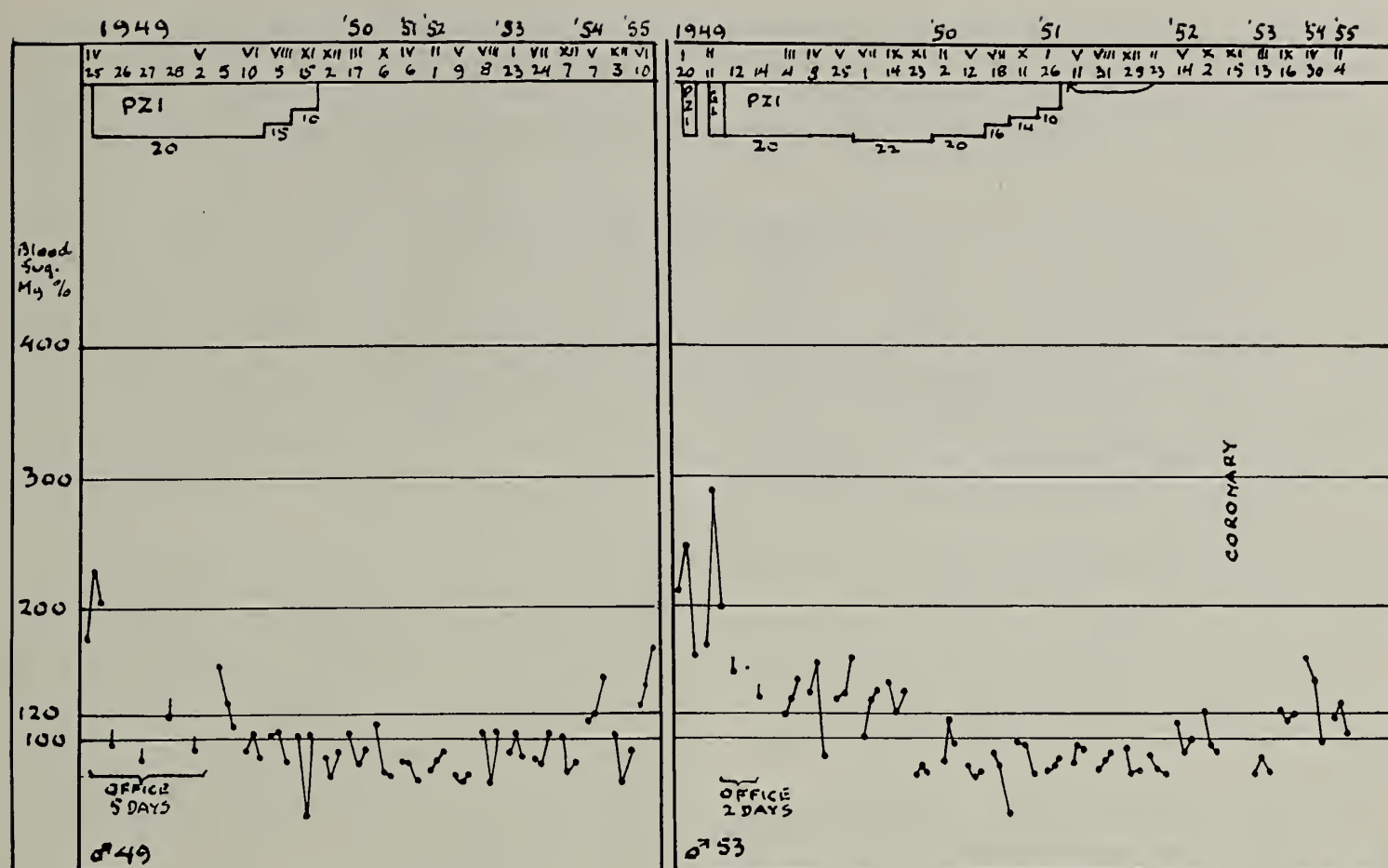


CHART 4

of age. He states that glycosuria was first found 20 years ago, following flu, on routine examination in Philadelphia. He was told that he was not a diabetic. Since then he has had many urine examinations, all negative for sugar. A week ago before I saw him, glycosuria was again discovered and the blood sugar that day was 200 mg. per 100 ml. There is no history of diabetes in the family. His present weight is normal, also the blood pressure.

When I checked him March 12, 1951, his blood sugars were: 200 - 300 - 200 and glycosuria was present throughout the day. I immediately gave him that same evening 20 units NPH insulin and after six days in the office, watching the fasting blood sugar which gave me the information as to the overall dosage of insulin, the blood sugar came down to normal on 30 units NPH insulin. As time went on, I was able to reduce the insulin dosage to 8 units a day. On Nov. 19, 1951, namely 8 months from the start, all insulin was discontinued. When you follow the chart you can see what a smooth course this man had right from the start to date. He did not lose a single day from his work.

Chart 3. (Case 2 at the right): Female, 64 years of age in 1947. Observations extend to 1953 when she was 70 years old. She came in with the history of glycosuria. Her weight was normal, Blood pressure 200/110. On the first day I checked her the blood sugars were: 217 - 282 - 316 and a heavy glycosuria throughout, 1 plus albumin, which cleared up later on and 2 plus acetone in the urine. That same evening

I gave her 25 units PZI and checked her fasting blood sugar for next 10 days. After that she was on her own, well controlled on 30 units PZI as can be seen from the chart, and on liberalized diet.

In two weeks I was able to discontinue all insulin and she ran a normal blood sugar level ever since. In 1949 she was in a severe auto accident in the West, was hospitalized for six months and when I rechecked her four times after that, she is still well controlled without insulin, just on slightly reduced carbohydrate diet.

Chart 4: (Case on the left): Male, 49 years of age. He states that he has had yearly urine examinations. Two years ago glycosuria was first found. His family physician found a heavy glycosuria few days ago and sent him to me. His father died of diabetes. He is 20 per cent overweight, blood pressure is normal. No other interesting point in his history.

When I first checked him, April 25, 1949, his blood sugars were: 187 - 230 - 207 and glycosuria throughout the day, no albumin, no acetone. That same evening I gave him 20 units PZI and after checking the fasting blood sugar for five days, it was evident that he could manage on this dosage. Subsequent checks show a normal level of blood sugars and after seven months all insulin was discontinued and one will note the normal level of blood sugars he ran to date over a period of five plus years.

Chart 4: (Case on the right): Male, 53 years of age. He states that glycosuria and hyper-

glycemia had been found off and on since 1943 (seven years). Few days previous to my seeing him, his blood sugar was 280 mg. per 100 ml. fasting. There is no history of diabetes in his family. He is 22 per cent overweight, blood pressure 170/110.

When first seen, Jan. 20, 1949, his blood sugars were: 214 - 250 - 162 and a heavy glycosuria throughout, albumin 1 plus, no acetone. I gave him 20 units PZI that same evening and since I had to be absent from the city, I did not see him until Feb. 11, when his blood sugars were: 170 - 292 - 200, a heavy glycosuria throughout and albumin 2 plus at this time. That same evening I gave him 20 units of globin insulin and he came the next morning for his check, the next two days the fasting blood sugars being 150 and 132 on 20 units PZI. He took this amount of insulin and in time, two years later, I was able to discontinue all insulin and he has been running a normal course ever since to date. He did not reduce his weight and in 1952 he had a coronary occlusion.

Chart 5: (Case on the left): Female, 52 years old. Observations extend over six years. She came in with the complaint that glycosuria had been found recently and the blood sugar at that time was 320. She feels fine except the pain in her legs. She has a bad diabetic history: mother, father, maternal grandfather, uncles, aunts, brother, all died of diabetes.

On the first day I checked her the blood sugars were: 272 - 258 - 250 with glycosuria throughout. There was no albumin and no acetone in the

urine. Her weight is normal, blood pressure 176/90. That same evening I gave her 10 units of insulin and 20 units of protamine zinc insulin. Repeated morning checks on 20 units PZI brought the fasting blood sugar to normal in five days. After that she was on her own and with the exception of the first subsequent check she was under perfect control even after all insulin was discontinued on April 11, 1950, for a period of 4.5 years. Then she got careless in her eating and in 1954 the blood sugars rose considerably so that insulin had to be resumed. On this, in a short time the blood sugars were under control and in six months all insulin was discontinued and she has done well since then as she was watching her diet closely.

Chart 5: (Case on the right): Male, 64 years of age. Observations extend over three years. There is no history of diabetes in the family. His weight is normal. Glycosuria had been found 30 years ago and off and on ever since. A week ago his fasting blood sugar was 240. He feels fine and is on diet. Has had nocturia for years. His weight is normal, blood pressure 118/82. Prostate enlarged.

When I checked him on the first day, Dec. 23, 1952, the blood sugars were: 256 - 150 - 187 with a heavy glycosuria all day. There was no albumin, no acetone in the urine. Rechecks of the fasting blood sugar at the office for the next six days came down to normal on 20 units of NPH insulin. Note that the progress has been fairly smooth. A recheck on May 23, 1955, showed the blood sugars as: 111 - 111 - 78 with no glycosuria.

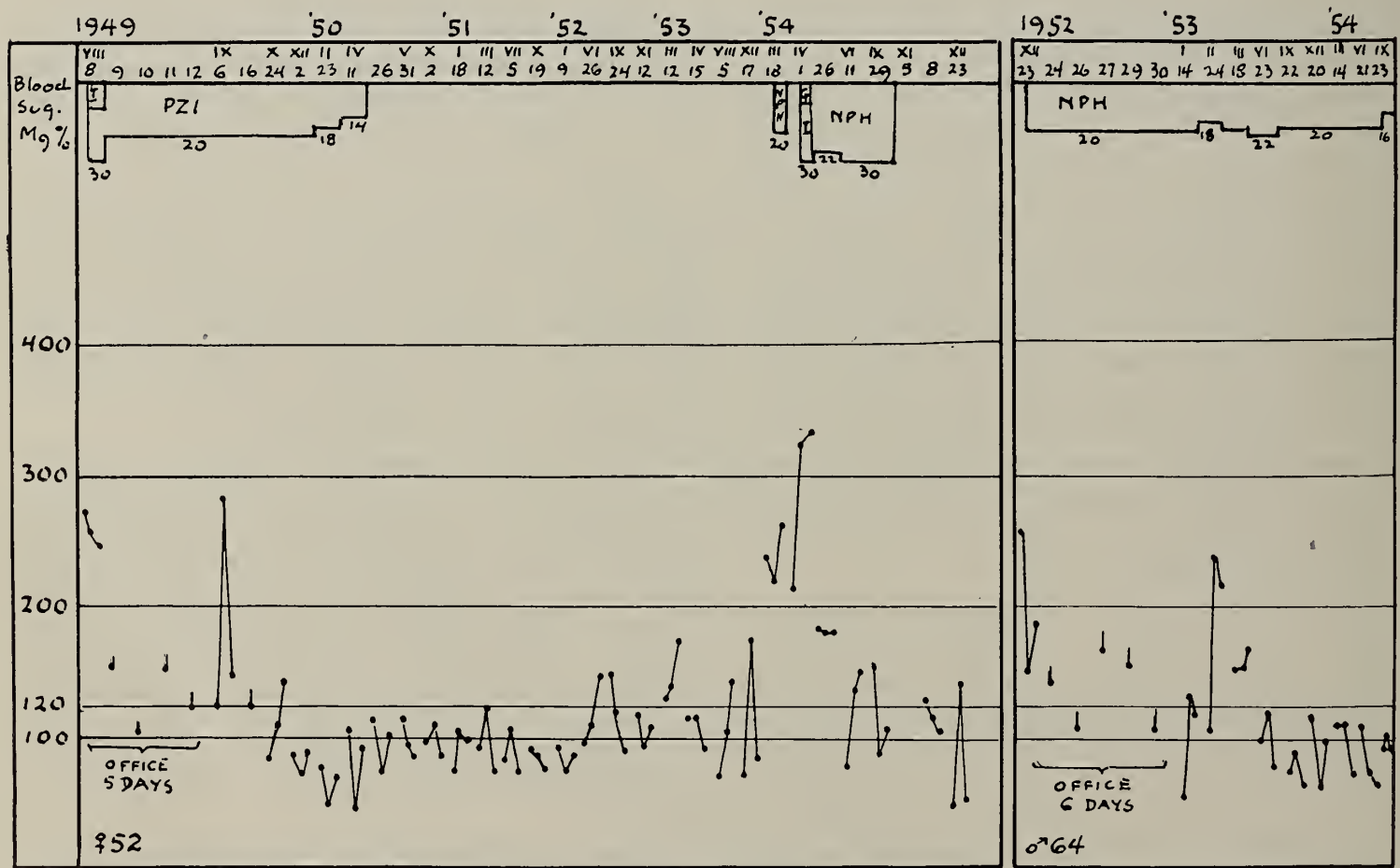


CHART 5

Diagnostic Procedures in Diabetes Mellitus

A Clinical Review of Five Hundred and Forty-Five Cases

FRANK W. ANZINGER, M.D.

DETECTING the unknown diabetic at an early stage of his disease continues to be a challenge to medicine. Pleas for more careful attention to the task have been made repeatedly by well known experts in this field.

The aims of this paper are to reiterate this plea, to re-state the reasons why an early and correct diagnosis is important, to describe diagnostic procedures and various tests used therein, and to present significant findings from the 450 cases of diabetes which I have treated in my 18 years of private practice. Besides the 450 cases, 95 additional ones referred to me as possible diabetics were studied and proven not to have the disease.

Since 1948, the American Diabetes Association has sponsored an annual drive to uncover the 1,000,000 diabetics known to exist and as yet undiagnosed.¹ The drive has been successful in that approximately 50,000 are uncovered annually.

The following are three reasons why an early diagnosis of diabetes is important:

First, it is believed that early treatment may reverse early pathological changes and thus prevent the patient from becoming a severe diabetic.²

Secondly, early treatment can prevent such complications as diabetic coma, degenerative vascular disease, et cetera.

Lastly, by discovering and treating diabetes early, we are better prepared to manage the diabetic patient who faces surgery (50 per cent), acute infections, and pregnancy.

To make a diagnosis of diabetes, just as in any other disease, one must have a high degree of suspicion of it. For this reason, I present my findings in 450 private cases with the hope that they may help in knowing where to look for the unknown diabetic.

HEREDITY

It has been shown statistically that diabetes occurs four times more frequently among the relatives of diabetics than in patients with no diabetic relatives. This was true in my series, the exact percentage being 28.

AGE INCIDENCE

Diabetes occurs more commonly between the

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ages of 50 and 70. This series of cases showed the following age distribution:

Ages	No of Cases
0-10 years	10
10-20 "	25
20-30 "	35
30-40 "	55
40-50 "	80
50-60 "	110
60-70 "	90
70-80 "	40
80-90 "	5

SEX INCIDENCE

In my series of 450 cases, 37 per cent were male; 63 per cent were female.

Several conditions in the female patient should arouse suspicion of diabetes; for example, coronary disease in the premenopausal age group, pruritus vulvae, leukorrhea, and cervicitis. Gallbladder disease is quite frequent among female diabetic patients.

One author has reported that 62 per cent of a group of diabetic mothers studied gave a history of having at least one child that weighed over 10 pounds at birth. In my series there were born of diabetic mothers, 46 babies weighing nine pounds and over at birth. The distribution was as follows:

Weight of Infant at Birth	No. of Cases
9 pounds	15
10 "	12
11 "	8
12 "	8
13 "	3

SYMPTOMATOLOGY

In the 450 cases there was the following distribution of symptoms: polyuria, 71 per cent; polydipsia, 70 per cent; polyphagia, 56 per cent; pruritis, 56 per cent; loss of strength, 54 per cent; loss of weight, 54 per cent; eye changes, 53 per cent; neuritis, 37 per cent.

Under eye changes, 94 had impaired vision;

79 needed glasses; 42 had diabetic retinitis; 16 had cataracts; 5 had diplopia; 3 were totally blind; and one had a retrobulbar neuritis that disappeared when the diabetes was brought under control.

Other symptoms mentioned in the literature were not significant in this series; namely, acromegaly, 25 per cent; Cushings's syndrome, hyperthyroidism, carbuncles, gangrene, et cetera.

LABORATORY PRECAUTIONS

A fair number of patients in this series, on being told they had sugar in the urine, placed themselves on starvation diets before returning for a diagnostic study. Fear or the reluctance to take insulin apparently prompted them to do this. A safeguard in such situations is a preparatory diet containing 300 grams of sugar for a period of three to five days before carrying out any laboratory procedures. If there is any indication that a patient is not cooperating in observing the diet, then hospitalization will give the only true picture.

For several reasons, I have found a specimen of fresh urine collected in the office laboratory and preferably after a heavy meal, to be more reliable. One young deceptive patient brought in a sample of tap water, naturally sugar free. The specimen collected in the office, however, tested 3 plus. A specimen which stands overnight may change from a 4 plus to a negative test. Hence, it is important to supply the patient with a urinary preservative if a fresh specimen is not used.¹

One should not rely on fasting blood sugars completely for the diagnosis of diabetes. These have been known to be normal even in the true diabetic.

I have observed that physicians are inclined to dismiss as insignificant cases of glycosuria following intravenous glucose therapy. There have been a number of such cases in which the diagnosis of diabetes was missed for months because the glycosuria was not investigated further.

Lastly, all cases of leukorrhea, cervicitis, and pruritus vulvae should be checked thoroughly for the possibility of diabetes. Probably all of us have seen patients treated for months for these conditions, only to have them promptly cured once the diagnosis of diabetes was made and treatment begun.

As a screening device, I have found it advantageous to run postprandial urine sugar tests on hospitalized patients. If they are positive, then blood sugar determinations are carried out.

LABORATORY PROCEDURES

BLOOD INSULIN DETERMINATIONS

Will the determination of insulin in the blood help in making a diagnosis of diabetes? Not

exactly. Most diabetics have been shown to have blood insulin levels within 70 per cent of normal. In a severe diabetic there may be no blood insulin while in the mild case, the levels may be within normal range.

USUAL DIAGNOSTIC PROCEDURE

Ordinarily, a complete history and physical examination will lead the physician to suspect and diagnose a case of diabetes. In most cases, a blood sugar determination made while the patient is in the office will establish the diagnosis.

Today we rely on the Folin Wu method of determining venous blood sugar. This method, however, has its weakness. It tests, approximately 10 to 30 mg. per 100 ml. of non-glucose reducing substances and one author has reported as high as 78 mg./100 ml.² A more nearly perfect method is that of Somogyi.

The following data suggest at what values the patient becomes a diabetic:

Folin Wu

Fasting	130 mg./100 ml. or more
1 hour	170 mg./100 ml. or more
2 hour	130 to 140 mg./100 ml. or more
3 hour	120 mg./100 ml. or more

Somogyi

Fasting	110 mg./100 ml. or more
1 hour	150 mg./100 ml. or more
2 hour	110 mg./100 ml. or more

PRECAUTIONS TO BE TAKEN IN CARRYING OUT AN ORAL GLUCOSE TOLERANCE TEST

Occasionally one must rely on the glucose tolerance test for the diagnosis of diabetes. In my experience, I have not used the test more than twice a year.

It has been pointed out that normal persons may give a typical diabetic tolerance curve if they have been on restricted diets. These same persons may show normal glucose tolerance curves one week after being given preparatory diets of 300 grams of sugar daily for three to five days.

A second consideration is that an individual confined to bed may have an abnormally high glucose curve. This may return to normal within two to six months after the patient has become ambulatory.

Thirdly, insulin should not be administered for one week preceding the test.

Fourth, patients having the test should be free of infections, fevers, head injuries, intracranial infections, cerebral vascular accidents, asphyxia, and chemical poisons.³

Fifth, patients with hyperthyroidism should have this condition corrected before making the diagnosis of diabetes unless they co-exist. Joslin and his group state that a one hour postprandial blood sugar of over 200 mg. per 100 ml. is neces-

sary for making a diagnosis of diabetes in the presence of hyperthyroidism.

Sixth, patients with hepatic impairment may give false positive glucose tolerance curves.

Lastly, one author states that smoking may increase the glucose level 50 per cent.⁴

AMOUNT OF GLUCOSE USED IN ORAL GLUCOSE TOLERANCE TEST

To patients 3 years of age and under, 3 grams of glucose per kilogram of body weight is given. For patients over 3 years of age, 1.8 grams of glucose is used up to a maximum of 100 grams of glucose.

The oral route for administering the glucose in a glucose tolerance test is generally relied on, because it is claimed to be more sensitive than the intravenous route.

INTERPRETATION OF GLUCOSE TOLERANCE TEST

For interpretation of this test, refer to references made in the foregoing paragraph on Usual Diagnostic Procedures.

In alloxan diabetes, the first change to occur in the glucose tolerance curve is the one hour postprandial blood sugar. Joslin's group has long held this determination an important one. Not all are agreed as to its value, but in my opinion, those who consider it will be less likely to miss the diagnosis of early diabetes.

There are a few conditions, unrelated to diabetes, that may give an abnormally high one hour postprandial blood sugar; namely, hyperthyroidism, gastroenterostomy, and liver disease.

It is generally agreed that by the end of two hours the blood sugar normally should have returned to 120 mg. per 100 ml. If it is 130 to 140 mg. or more, the patient is considered to be a diabetic.

INTRAVENOUS GLUCOSE TOLERANCE CURVE

In such conditions as hyperthyroidism and gastroenterostomy we rely on the intravenous glucose tolerance test,³ because in both of these conditions the absorption of glucose in the intestinal tract is too rapid to give helpful values.

The amount used for the test is 0.5 grams of glucose per kilogram of body weight given in a 20 per cent solution intravenously over a period of one-half hour. Blood sugar determinations are then made at 30, 60, 90, 120, and 180 minute periods. The curve should return to normal in one and a half hours. If the blood sugar remains over 130 mg./ml. at the end of two hours, the curve is considered diagnostic for diabetes.

INTRAVENOUS GLUCOSE TOLERANCE TEST IN DIABETES AND LIVER DISEASE

In liver disease, the fasting blood sugar is generally subnormal (80 mg./ml. or less) with a rise to a possible 320 mg. one hour after the injection of glucose. The curve then returns to

normal at the end of two hours. If diabetes and liver disease co-exist then the height of the curve may rise to over 400 mg. and fail to return to normal at the end of two hours.^{5, 6}

SCREENING TEST FOR THE DETECTION OF POTENTIAL DIABETIC PATIENT

More emphasis is being placed recently on those diagnostic procedures that may help in predicting what patients will become diabetics.

Dr. Jörn Ditzel, associated with the Joslin group, has examined the corneal conjunctivae with a stereoscopic dissecting microscope and graded the changes found in the blood vessels. Abnormal findings were listed as follows: prolongation of the capillaries and venules; dilatation of the venules, cork screw formation of the capillaries; and aggregation of blood vessels. Dr. Ditzel found those cases receiving a Grade III classification to have abnormal glucose tolerance curves.

More recently, Conn has introduced a test based on the stress factor. In this test he gives cortisone orally every eight hours for several days and then runs glucose tolerance curves. It will take more time to determine the value of this test.

A very practical method of uncovering diabetics is to follow all patients showing glycosuria. In the Medical Review of the *New England Medical Journal* (September 4-11, 1952), the following facts were brought out. Twenty-nine per cent of patients having a glycosuria will become diabetics by the end of 10 years. Forty per cent of patients with glycosuria and an elevated one hour postprandial blood sugar will become diabetics in the same period. This certainly should suggest to every practitioner that every patient with glycosuria should be watched carefully throughout his life.

CONCLUSIONS

This paper has been prepared and presented in the hope that it will stimulate greater interest in the detection of diabetes and to offer diagnostic procedures I have found reliable in my care of the 450 cases of diabetes reviewed.

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Gastrointestinal Bleeding of Unknown Etiology

JACK E. TETIRICK, M. D.

THE determination of the source of gastrointestinal hemorrhage is a common, serious, and expensive clinical problem. Failure to establish a diagnosis hinders therapy and results in uncertainty of prognosis.

The purpose of this article is to record the findings of a review of the subsequent course of patients who had one or several hospital admissions for gastrointestinal hemorrhage and in which the source of bleeding remained unknown after a thorough study. A review of such patients after a period of time had elapsed since the episode might well provide some information as to what the eventual diagnosis or diagnoses had been, and what events or studies, if any, were helpful in finally establishing the diagnosis. In addition, it was of interest to learn what the course of these patients had been both with and without surgical intervention, and whether the delay or failure to establish the source of hemorrhage had altered the prognosis.

SELECTION OF PATIENTS

The records of all patients admitted to the Massachusetts General Hospital on both the private and ward services with a diagnosis of gastrointestinal hemorrhage between the years 1947 and 1953 inclusive were reviewed. Cases selected for study fulfilled the following criteria:

1. *The patient was bleeding on admission to the hospital.*

Patients referred to the hospital after bleeding had ceased were not accepted for study. Proof of bleeding was established in every instance by a positive guaiac reaction of the vomitus or stool or by the passage of obvious gross blood.

2. *A definite source of bleeding was not established.*

A few patients were discharged with a diagnosis of "duodenal ulcer" or "gastritis" without evidence either clinically or radiologically that this was, in fact, the diagnosis. These cases were included in the series. A radiographic duodenal deformity was not taken as conclusive evidence that the bleeding originated in a duodenal ulcer. If a duodenal ulcer crater was seen or "probably" seen by the radiologist this was accepted as the likely source of hemorrhage and the case was not included in the series. Patients discharged with a diagnosis of "gastrointestinal hemorrhage of unknown etiology," comprise the rest of the patients studied.

The Author

• Dr. Tetirick, in private practice in Columbus, completed residency in surgery at The Massachusetts General Hospital, July 1956.

3. *There was adequate opportunity for study of the patients.*

Patients who were moribund, those who underwent immediate surgery, or for other reasons did not have a thorough study were not included. If, after complete but inconclusive study, the source of bleeding was established by surgery or postmortem examination, the case was included. Although these patients did not leave the hospital as unsolved diagnostic problems, they were instances in which diagnostic efforts were pursued to an end point.

Of the patients accepted for the present roster of cases the following points were determined from the record: Age, sex, date and duration of admission, manner and amount of bleeding, previous bleeding episodes with date and amount, previous and present x-ray studies, relation of x-ray studies to time of bleeding, sigmoidoscopy, gastroscopy, gastric analysis, associated diseases, symptoms, alcohol and drug ingestion, serial recording of hemoglobin levels, stool guaiac studies, and the follow-up history. A re-admission was treated in an identical manner.

ANALYSIS

1. GENERAL DESCRIPTION

There were 86 patients included in the study. There were 46 males and 40 females. The average age was 58* years and there was no significant difference between sexes in this respect. Occupation, economic level, and associated diseases varied widely and did not appear of significance. Exception is noted for the presence of multiple past epistaxes in two cases, and the presence of multiple neurofibromatosis in one case as will be discussed in later paragraphs.

A careful study was made for important subgroups, such as those patients using alcohol. Only seven patients used alcohol in quantity of two bottles of beer or ale or more a day or its alcoholic equivalent, and in this small group the use of alcohol had no apparent diagnostic significance.

Patients were also subgrouped according to

Submitted August 2, 1956.

*Excluding one 19 month old male infant.

age and sex, and according to severity of symptoms. The course of none of these subgroups was significantly different from the entire group.

2. SYMPTOMS

Forty-five patients (52 per cent) had no past gastrointestinal symptoms. Sixteen (19 per cent) had mild or vague symptoms such as infrequent epigastric discomfort, postprandial epigastric "bloating" or occasional episodes of vague nausea not productive of vomiting. Fifteen patients (17 per cent) had moderate symptoms consisting of epigastric discomfort or pain occurring as often as once a week, or postprandial "heartburn" with the use of sodium bicarbonate, hot water, or proprietary medicines once a week or less. Only nine patients (10 per cent) had severe gastrointestinal symptoms of definite epigastric pain related to meals, postprandial vomiting, or the use of antacids daily for prolonged episodes of gastrointestinal distress. The sex distribution of moderate or severe symptoms was 17 males, and 7 females, a ratio which deviated from the nearly equal sex distribution of the entire series and approached the sex distribution of patients with known duodenal ulcer.

The symptoms which immediately preceded the bleeding episode were epigastric discomfort or a "small" sharp epigastric pain in 24 patients (35 per cent). Seven patients (8 per cent) complained of nausea for a period as long as two days prior to bleeding, three patients had malaise and symptoms of an upper respiratory infection, one patient fainted, but 49 patients (57 per cent) had no premonitory symptoms. In two patients no statement of immediate symptomatology was recorded. There was consistent prompt subsidence of symptoms after hospitalization. No patient had severe or even moderate pain or nausea after the first hospital day.

3. CLINICAL BEHAVIOR OF THE BLEEDING EPISODE

The character of the hemorrhage in this group of patients was, in most cases, moderate in amount, and tended to subside promptly after hospitalization. Studies were not performed or recorded which allow accurate determination of the amount of blood loss, but certain factors allow an estimate of the blood loss. There were no deaths from hemorrhage at the first admission for bleeding of unknown etiology. Twenty-nine patients (34 per cent) required no blood transfusions, 66 patients (76 per cent) required three or less transfusions. The admission hemoglobin level averaged 10.2 grams (Sahli).

The duration of bleeding was estimated from the history of onset, the subsequent clinical notes, the behavior of the hemoglobin level, and the serial recording of the guaiac reaction of the stool. In those patients who stopped spontaneously the average duration of bleeding was

eight days.** The average duration of bleeding after hospitalization was four days.**

Only two patients bled for longer than 20 days. The duration of bleeding in these two patients was 30 days for one (Case 1) and 34 and 49 days on two separate admissions for the other (Case 2). The presence of multiple past epistaxes in both patients, and the subsequent proof that one of them (Case 2) had multiple telangiectases appears to justify holding the tendency to prolonged bleeding while in the hospital as having diagnostic significance. Recurrence of bleeding in the hospital was very rare.

Twenty patients (23 per cent) had a further episode or episodes of gastrointestinal hemorrhage following the first admission for gastrointestinal hemorrhage of unknown etiology. There was no mortality at the first admission. Four of the twenty patients who had further hemorrhage died of that hemorrhage, or of some complication directly related to it (20 per cent mortality in 20 patients). One of these patients died of continued hemorrhage following exploration and the finding of multiple telangiectases. A second died of congestive heart failure following a period of recurrent hemorrhage. The third patient died on the first postoperative day following an emergency subtotal gastrectomy for massive recurrent hemorrhage. And the fourth died of massive recurrent hemorrhage from a gastric ulcer without surgical intervention.

4. THE EVENTUAL DIAGNOSIS

Eighteen patients (21 per cent) of the total series had a source of hemorrhage proven. The most common eventual diagnosis was gastritis. This was found in 11 cases, or 61 per cent of the cases in which a diagnosis was eventually established. Two cases (11 per cent) had duodenal ulcers. The other diagnoses were one each of multiple telangiectases, neurofibroma of duodenum, gastric ulcer, gastric carcinoma, and traumatic erosion of the gastric mucosa by a splinter of wood.

The most commonly employed diagnostic test was fluoroscopic examination of the behavior of a barium suspension in transit through the esophagus, stomach, and upper intestine. In this hospital the initial barium swallow is a thick suspension for the purpose of delineating the esophagus. In the present study there were no esophageal varices seen, and in no instance did a patient return at a later admission with bleeding esophageal varices. This suggests that the barium test, and the clinical and laboratory appraisal of the patients in this series is effective in ruling out the diagnosis of bleeding esophageal varices. This inference, if accurate, would be most helpful when continued severe hemorrhage,

**Excluding 12 patients with occult bleeding for whom the duration of bleeding cannot be estimated.

or recurrent hemorrhage at a later admission forces urgent surgical intervention.

Every patient had an upper gastrointestinal roentgenographic series. Forty-one patients had two or more such examinations. In the opinion of the roentgenologist these examinations did not reveal the source of hemorrhage. Twenty-eight patients (33 per cent) had completely negative examinations. In the other 58 (66 per cent) there was some variation from the "normal" noted by the radiologist and the clinician but was not considered pertinent. These abnormalities were some change of the gastric mucosa ("swollen folds" "retained secretions and antral spasm") (28 per cent), hiatus hernia (30 per cent), duodenal deformity (26 per cent), duodenal diverticulum (12 per cent).† In retrospect only two of these abnormalities appeared to have any significance.

The presence of duodenal deformity was, in some instances, the sole basis on which an active duodenal ulcer was predicated as the source of the hemorrhage. This impression was not substantiated by the future course of this group of patients, only two of which later proved to have a bleeding duodenal ulcer, and of these one had no deformity by x-ray. Five patients in whom a duodenal deformity was noted had some other source than a duodenal ulcer as the proven origin of a later episode of hemorrhage.

The fact that some mucosal abnormality was noted but not considered pertinent appears to have more significance than was accorded to it. This impression is supported by the frequency with which gastritis was the eventual diagnosis. This mucosal abnormality occurred more frequently in the first and was often absent in the second consecutive gastrointestinal series done on a single admission. It was more likely to be found if the patient was bleeding at the time the examination was performed, and was more often found if the examination was made early rather than late in the hospital stay.

Twenty-eight barium enema studies were performed on 25 patients; none were considered diagnostic for the source of hemorrhage.

The next most common diagnostic test carried out on these patients was gastroscopy performed seven times on seven patients. Four were negative, two showed atrophic gastric mucosa, and one a small gastric polyp. These abnormalities were considered to have no certain relationship to the episode of hemorrhage. None of these patients was actively bleeding at the time of gastroscopy. This is in sharp contrast to three other patients in the series who had the source of a later hemorrhage established by a gastroscopy while they were actively bleeding. The diagnosis in all three instances was gastritis, and although the number of instances is

small, it is suggested that the gastroscope can be more effectively employed as a diagnostic instrument if the patient is examined at the earliest opportunity, preferably while bleeding is still active.

5. THE ROLE OF SURGERY

(A) Diagnosis

Surgery was used in an attempt to establish the diagnosis at a time of election in only nine cases (10 per cent). Exploration of the abdomen failed to yield any evidence of the diagnosis in six of these nine cases. It yielded the proper diagnosis in two cases (duodenal ulcer, neurofibroma of duodenum) and an incorrect diagnosis in one case, (gastric ulcer—proven by specimen to be gastric carcinoma). Of the six patients in whom the exploration was negative, two patients have never had the source of hemorrhage identified. In the other four patients, the surgeon proceeded with a subtotal gastrectomy and the specimen yielded the diagnosis in every instance. (Three cases showed gastritis, one showed a traumatic erosion of the gastric mucosa by a splinter of wood).

In three other cases laparotomy was performed because of continuing or recurrent hemorrhage. The diagnosis was established at exploration in every instance and confirmed by resection in the two cases in which it was performed. (One patient had multiple telangiectasis, no resection was performed. One patient had a duodenal ulcer and gastritis; one patient had bleeding gastritis, and distal subtotal gastric resection was performed in these two cases).

(B) Treatment

The therapeutic value of the surgical procedures is difficult to assess due to the variety of procedures and diseases involved. Three cases had exploratory laparotomy alone. Two of these cases have had no further hemorrhage and the source of bleeding remains unproven. The third, as previously mentioned, died of bleeding telangiectases of the small bowel. One case of neurofibroma of the duodenum with excision, and two patients with duodenal ulcer and gastric carcinoma respectively are doing well after distal subtotal gastric resection. One patient had a distal subtotal gastric resection following a negative exploration, and the specimen showed the source of hemorrhage to be due to a gastric erosion around a piece of wood imbedded in the gastric wall. Presumably gastrotomy and extraction of the splinter would have been sufficient therapy for this patient.

The other five cases in which surgery was performed had gastritis. One patient had, in addition, a shallow duodenal ulcer that was not bleeding at gastrotomy whereas the gastric mucosa was bleeding. Two of the five cases had surgery performed as an emergency, one of these patients died. The other four survived, three are well

†The above mentioned abnormalities occurred singly or in various combinations.

without recurrent hemorrhage, one patient has had four further episodes of gastrointestinal hemorrhage.

Of the four elective surgical cases in which the surgeon decided to proceed with a distal subtotal gastric resection in the absence of diagnostic exploratory findings there was no mortality, and the source of hemorrhage was established in every instance; but one of the resections was unnecessary (splinter of wood imbedded in gastric mucosa), and one of the patients has had further episodes of gastrointestinal hemorrhage.

(C) Mortality

Two of the 12 patients who had surgery died in the hospital. There were no deaths among the nine elective cases. One of the deaths occurred on the first postoperative day following resection performed as an emergency for severe hemorrhage in a 75 year old female during her second admission for hemorrhage of unknown source. At the time of surgery the source was proven to be gastritis. The second surgical death occurred in a 76 year old male who underwent exploratory laparotomy in the fifth week of continued and recurrent gastrointestinal bleeding. Multiple telangiectases of the small bowel were found. Death occurred in the second postoperative week from continued hemorrhage, inanition, and pulmonary sepsis.

As previously mentioned, there were two other fatal cases. In one, an 87 year old man, surgery was not feasible. Death was due to congestive heart failure complicating recurrent hemorrhage, and the source of the hemorrhage was never proven. The fourth fatality was during the second admission for gastrointestinal bleeding of unknown source in a 60 year old woman whose final massive hemorrhage was later proven at necropsy to have originated in a large gastric ulcer.

All of the deaths therefore were from recurrent hemorrhage, or its direct complications. In retrospect, there appears to be no possible salvage in two of the cases because of age or nature of the disease. There remains the possibility that the other two cases could have been salvaged by distal subtotal gastric resection at a time of election. Reappraisal of these two cases in particular clearly demonstrates the value of early diagnosis of the source of hemorrhage in these patients. It seems unlikely, for instance, that the 60 year old female would have been allowed to leave the hospital with a large gastric ulcer had this fact been known to her physician at that time.

SUMMARY AND CONCLUSIONS

1. The records of 86 patients who had had one or more hospital admissions for gastrointestinal hemorrhage of unknown source during the years 1948 to 1953 inclusive were reviewed.

2. Eighteen of these patients eventually had

the source of their hemorrhage identified. The most common diagnosis established was gastritis.

3. The presence of some gastric mucosal abnormality by roentgenographic examination appeared to have more significance than generally accorded to it by the radiologist and clinician at the time of the admission. The presence of a deformed duodenal cap without demonstration of an active ulcer crater was of no diagnostic significance.

4. There was no mortality at the first admission. The mortality of a second or later admission for recurrent hemorrhage was 20 per cent. The relation of the mortality to surgical intervention is discussed.

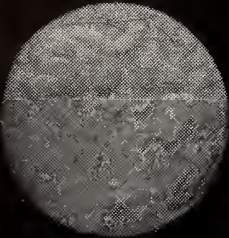
5. Surgery was used infrequently for diagnostic purposes. The results were disappointing when exploration of the abdomen alone was performed. The diagnosis was established in every instance when the surgeon proceeded with subtotal gastric resection in the absence of diagnostic exploratory findings (4 cases). The small number of surgical cases does not allow any conclusion about the wisdom of proceeding with subtotal gastric resection under such circumstances.

6. An aggressive attempt should be made to establish the source of hemorrhage early in the first admission for gastrointestinal bleeding. The apparent benign nature of the bleeding in some instances is deceptive and should not be allowed to deter diagnostic efforts.

Hypertensive Headache

The headache accompanying hypertension belongs in the vascular group. It is presumably due to distension and excessive pulsation of the basilar arteries of the brain. It is not necessarily related to measurable cerebral edema since it occurs just as frequently without objective signs of increased intracranial pressure as it does when those signs are present. This headache is, of course, seen only in patients with hypertension particularly of the diastolic variety. The degree of the hypertension is not necessarily proportional to the degree of the headache. A somewhat similar headache is occasionally seen in patients with arteriosclerosis and marked increase in the pulse pressure even though the diastolic pressure is not elevated.

This headache occurs quite regularly in the morning on awakening. It is felt as a dull, annoying discomfort either in the occipital, vertical or frontal regions. It usually does not show any particular predilection for one side of the head and is not accompanied by nausea or vomiting unless the hypertension is of the malignant nephrosclerotic type with nitrogen retention and increased intracranial pressure. Relief of this type of headache frequently occurs with satisfactory medical management of the hypertension—Perry S. MacNeal, M. D., Philadelphia: *J. Michigan M. Soc.*, 55:1074-1077, September, 1956.



MATERNAL HEALTH IN OHIO

A CONTINUOUS state-wide Maternal Mortality Study is being conducted in Ohio by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health and assisted by official representatives of the various County Medical Societies of the state.

Since work of the committee is educational as well as statistical, summaries of some of the cases studied by the committee, based on anonymous data submitted, will be published in *The Ohio State Medical Journal* from time to time. Each presentation will be brief but informative. It will contain opinions of the committee, based on the data submitted for review. Three cases of maternal death due to toxemia are presented in this third report.

CASE NO. 48

This patient was a 15 year old, white, gravida II, abortus I, at term, who died undelivered. In her past history, she was said to have "kidney trouble," details of which are lacking; in August of the previous year, the patient had an abortion, followed by amenorrhea. Her last menstrual period was indefinite, some time late in August, with an estimated date late in May (?). In April the patient was admitted to the hospital for "false labor"; hydronephrosis was discovered by a consultant, and the patient was discharged with directions to use the knee-chest position which relieved the symptoms.

On June 3 (a month later) her family physician saw her in his office with complaints of "faintness," frontal headaches and blurred vision for the past two to three weeks. There was slight edema of the hands and feet, blood pressure 146/110, and the urine revealed 4 plus albumin. Ammonium chloride, castor oil and a low salt diet were prescribed and the patient was sent home. The same evening, the physician was called to see the patient in convulsions; 75 mg. sodium secenal® was administered intravenously, and after two more convulsions, the patient was admitted to the hospital maternity ward June 4, 1:20 a.m. She was at term, not in labor, was restless, was in a light coma, and responded only to painful stimuli. Blood pressure was 176/30, fetal heart tones 90, and no edema was noted.

Laboratory data on admission revealed: Hemoglobin 17 Gm., erythrocytes 5.38 million, leukocytes 23,700, with polymorphonuclear leukocytes 96 per cent, lymphocytes 4 per cent; nonprotein nitrogen 79.8 mg., uric acid 3.5 mg., carbon dioxide combining power 25 volume per cent (11.2 mEq.), albuminuria 4 plus (21.6 Gm. per liter), Addis count leukocytes 633,270 per cubic mm., erythrocytes 1.26 million per cubic mm.

Therapy included: 3 Gm. magnesium sulfate in 1,000 cc. of 20 per cent glucose in distilled water. At 2:45 a.m., June 4, 6 Gm. magnesium sulfate was administered intramuscularly; the blood pressure was recorded at 170/120, and the fetal heart tones were 160. At 4:00 a.m. the blood pressure was 180/140, the pulse 120, and at 4:50

a.m. the blood pressure had risen to 190/150. Therapy included 160 mg. amytal® (intramuscularly) and 5 mg. unitensen® in 500 cc. of 20 per cent glucose in distilled water with 20 mg. apresoline.® By 6:00 a.m. the blood pressure was 150/110, with a pulse of 44. Blood pressure and fetal heart rates were recorded regularly and by 11:00 a.m. the blood pressure was 124/106, pulse 100, respirations 227, fetal heart tones 126. The patient was restless. Morphine sulfate 1/6 gr. was given.

At 12:45 p.m. the patient suddenly became cyanotic, dyspneic and developed rales in her chest. The blood pressure fell rapidly to unobtainable levels. The patient was placed in the shock position, nasal oxygen was given, and secretions were removed from the pharynx by suction. The pupils were fixed and dilated; no reflexes were obtained. At 1:10 p.m., 10 mg. nalline® was given intravenously. The patient did not respond to any stimuli. She deteriorated progressively in spite of therapy, the blood pressure never exceeding 54/30, and she expired in approximately five hours. Autopsy permission was obtained.

Pathological diagnosis: Extensive subdural hemorrhage of the left cerebral hemisphere; intracranial hemorrhage left parietal lobe; multiple subcapsular hemorrhages of the liver; medullary hemorrhage of the kidneys; petechial hemorrhages of gastrointestinal and respiratory tracts; mild pulmonary edema. (Cause of death also included: Eclampsia.)

COMMENT

It was quite obvious that the patient received inadequate prenatal care during her pregnancy; whether her physician advised her to seek visits more frequently and she failed to follow the advice, or whether advice was lacking is not clearly established in the information available. Weight gain throughout the pregnancy was not estimated. After evaluating the information available in the case, the Committee voted the death preven-

table, principally on grounds that the patient should have been hospitalized for vigorous "antitoxemic therapy" several weeks before her final admission on June 4.

CASE NO. 5

This patient was a 38 year old, white, "primipara" who died 23 hours postpartum. In her past she had always been obese and "short" (weight 260 pounds, height 4' 11") and had been treated for hypertension. The last pregnancy went to term, but is listed as the third; it is assumed the previous two pregnancies terminated in abortion.

Prenatal care was considered adequate. Albuminuria developed the thirty-fourth week, with intermittent appearances of hypertension, throughout the last trimester, and with repeated signs of glycosuria. Last menstrual period was indefinite, but her estimated due date was set for sometime in January.

January 12 the patient was admitted to the hospital because of toxemia, with blood pressure 164/100, 2 plus albuminuria and "some edema" of the extremities; the plan included induction of labor. Fetal heart tones not heard (?); x-ray studies were not too satisfactory due to patient's obesity, but it was believed there was no cephalopelvic disproportion, yet it was the impression that the patient had a generally contracted pelvis. Induction of labor was begun with intravenous pitocin® after admission; that evening no fetal heart was heard. A sterile vaginal examination revealed a cervix 2 cm. dilated; the membranes were artificially ruptured.

Uterine contractions were ineffectual, even with further use of pitocin®; her blood pressure stabilized at 170/60. Labor progressed slowly, the patient's temperature and pulse rate became elevated, and her condition grew gradually worse. Her total labor, ineffectual as it was, was 18½ hours, with membranes ruptured 38 hours. After several informal consultations, (high) classical cesarean section was performed under spinal anesthesia (through a supra-umbilical abdominal incision) and a macerated stillborn fetus was delivered weighing 11 pounds, 7 ounces. The placenta was removed manually, oxytoxics were administered, blood loss was replaced.

Following this operation, the patient reacted well for a short time, then developed signs of marked shock (BP 120 range), rapid pulse, rapid respirations. Again the internist was called; he had previously seen her for "the diabetic state," and now a diagnosis of Sheehan's syndrome was made. The patient pursued a downhill course in spite of all medication, and died approximately 24 hours postoperative. Permission for autopsy was not obtained.

Comment by an internist: It is my opinion that this patient was unquestionably diabetic from the beginning, but the diabetic status was not correctly diagnosed in spite of apparent adequate studies. All clinical features support a diagnosis of diabetes; it is not recorded on the hospital chart.

Cause of death: (certificate) Acute pituitary necrosis (Sheehan's syndrome); Pregnancy uterine term delivered, cesarean section; obesity.

COMMENT

Once again, the Committee felt it was hampered because of a lack of specific autopsy information. Furthermore, the Committee would have been helped in its evaluation of the case, by the specific data elicited from various laboratory studies referred to indirectly in the case summary; ap-

parently these were not available. Also, intermittent glycosuria was mentioned, occurring throughout the pregnancy, without a quantitative note to indicate change or severity. Obviously, the patient, at 38 years, had had some arterial hypertension prior to her pregnancy, with extreme obesity; hence, she became the hypertensive case, with a superimposed acute toxemia of pregnancy (pre-eclampsia), which was not mentioned on the certificate, as a contributory cause of death.

It was felt that Sheehan's syndrome was not a likely diagnosis in this case, since the features appear long after acute hemorrhage; furthermore, the amount of blood loss was not available, and the Committee was inclined to agree with the clinical diagnosis of diabetes, even though supporting laboratory proof therefor was lacking.

Members of the Committee voted this case a preventable death. It was felt that in this older "primipara" she should have had x-ray studies made earlier in her pregnancy, and that she should not have been subjected to as much as 18 hours of labor, before intervention.

CASE NO. 88

This patient was a 24 year old, white, Para II (last were twins) who died 1¼ days postpartum. Her past history was not remarkable. The first pregnancy went to term without complication, and delivered a living baby; the puerperium was uneventful. She registered with her physician in the second pregnancy at two months and she made a total of seven visits; the prenatal care was marked "adequate," yet it is stated that the patient gained 45 pounds in 7½ months. In her thirty-seventh week, the blood pressure rose to 144/72, and albuminuria was noted; according to the records, no special effort was made by the physician to treat either of these features. Serologic test for syphilis taken in the sixth month, was negative. A note of "no edema" was recorded before labor began.

Labor began spontaneously, at term, September 4th, and the patient was admitted to the hospital with blood pressure of 144/108, bilateral edema of feet and ankles (from nursing notes) and no urinalysis is recorded. Information is also lacking concerning the diagnosis of multiple pregnancy before delivery. But it is recorded that no intrapartum medication was given for the toxemia, and the patient received no medication of any kind.

The patient was prepared for delivery, and the first fetus was delivered as a breech single footling, left sacro anterior, spontaneously, first degree laceration. The second fetus was delivered soon spontaneously, vertex presenting, after total of about two hours of labor. Both babies were alive, with weights of 5 pounds 9 ounces, and 6 pounds 2 ounces, respectively. Cyclopropane was used for a time during the deliveries; the placenta was delivered in 10 minutes, complete.

Approximately 16 hours postpartum, the blood pressure was elevated, therapy was started. This consisted principally of 50 per cent glucose, two small doses of magnesium sulfate and small doses of sodium luminal,® all over the course of the next twelve hours. No hypotensive drugs were administered, and no laboratory work was done, nor is there any mention of consultation in the case.

The last mention of any medication was the

administration of morphine sulfate (presumably after a convulsion); the patient lapsed into coma, administration of oxygen was started, but the patient died. Autopsy permission was obtained.

Pathological diagnosis: (1) Liver necrosis with subcapsular hemorrhage (Classical of eclampsia). (2) Right hydronephrosis and bilateral hydro-ureter. (3) Diffuse myocarditis.

Cause of death (from the certificate): Puerperal eclampsia; pre-eclamptic toxemia; twin pregnancy, delivered.

COMMENT

The Committee voted this case a preventable death. It was apparent that several errors were present in the management of the case, namely: although the patient made a number of prenatal visits to the office of her physician, no action was taken to correct the toxemia which was progressing gradually but surely. When the toxemia was obvious at the 7½ month, no measures were employed to correct the weight gain, hypertension and albuminuria. As labor began, the toxemia was omitted from a standpoint of therapy and diagnosis (laboratory studies). Postpartum therapy for the toxemia was delayed until a time, when even heroic therapy could have provided little improvement in the patient's condition.

Glucose Tolerance in Coronary Heart Disease

The incidence of coronary heart disease in patients with diabetes mellitus is considerably higher than it is in the general population. A comprehensive review of the literature on this subject has been reported by S. Stearns *et al.* However, the reverse of the above situation, i. e., the incidence of impaired carbohydrate metabolism or diabetes mellitus in patients with pre-existing coronary heart disease, has not been explored as extensively.

Raab and Rabinowitz performed a standard one-dose, three-hour, oral glucose tolerance test on 21 patients with coronary occlusions. In 12 of these patients the test was performed within two weeks of the acute episode. All 12 revealed diminished glucose tolerance curves. In the nine remaining patients the test was performed from two months to five years after the acute coronary occlusion. In this latter group three revealed diminished glucose tolerance curves.

Our study was undertaken to determine glucose tolerance in 100 male patients who had sustained coronary occlusions from three months to 13 years prior to this investigation. Patients with previously diagnosed diabetes mellitus or other diseases associated with diminished glucose tolerance were excluded from the study; 41 of the 100 patients showed a diminished glucose tolerance curve. This represents a higher percentage than is found in a normal population.—Morris Lattman, M. D., and Harry Rudin, M. D., *New York City: New York State J. Med.*, 56:2836, September 15, 1956.

Franklin County Pelvic Cancer Delay Committee Report

By JOHN H. HOLZAEFFEL, M. D.
Columbus, Ohio, Chairman

The Franklin County Pelvic Cancer Delay Committee met at Columbus Health Center August 15, 1956, at 12 noon. Three cases presented.

Case 28: The patient, 40 years old, Para 0, abortus 1, was admitted in January with menometrorrhagia for 10 months, severe obesity, edema, and severe dyspnea and anuria. Nine months before admission she "flooded" and had noticed intermittent vaginal bleeding to date. Patient thought she was "in the menopause" and did not see a physician until several days before admission. Symptoms of pleurisy led to initial diagnosis.

On admission, condition was critical. Gynecological consultation obtained. Abdomen was huge, liver large, thick bloody vaginal discharge with clots. Pelvic examination was difficult due to obesity. Clots present in the vagina, cervix thin, 3 cm. dilated with some fibrinous foreign material in the os. Corpus seemed quite enlarged, but not definitely outlined. Impression: Uterine tumor, possible sarcoma. X-ray studies advised, followed by dilatation and curettage.

Patient expired late the following day. Autopsy report was anaplastic malignant tumor of the uterus, probably anaplastic endometrial carcinoma with widespread metastasis.

Comments: DR. JOHN H. HOLZAEFFEL: Ten months patient delay.

DR. ANTHONY RUPPERSBERG: This might have been discovered earlier had the patient reported for periodic pelvic examinations.

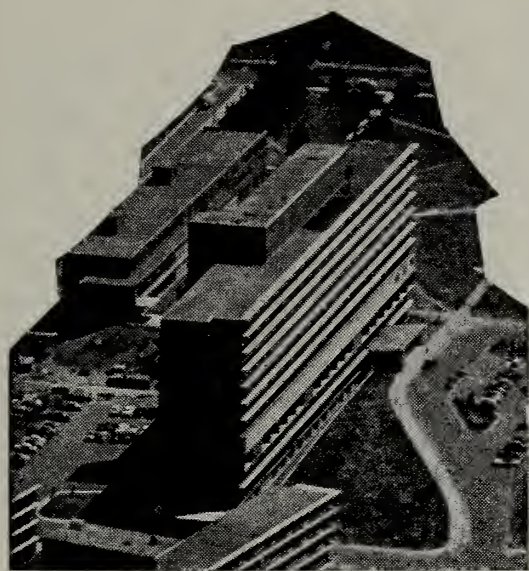
Case 29: The patient, 68 years old, Para II, seen in April; history of menopause at age of 48, and two months vaginal bleeding. (Previously her family physician had relieved her by explaining that recent nervousness was the etiology of her bleeding.) Examination revealed a serosanguineous vaginal discharge, clean cervix, uterus of large normal size. No pelvic masses; rectal examination negative. Papanicolaou smear negative. Patient was not interested in hospitalization, but agreed to be "watched along." Bleeding occurred again in June but she still refused hospitalization. Bleeding again in August and she was hospitalized for dilatation and curettage. Pathology report was: Well differentiated adenocarcinoma of the endometrium, grade II, Clinical Stage I. Radium, 6000 mc. administered. Periodic examinations revealed no recurrence.

Comments: DR. EDWIN ZARTMAN: The physician cannot rely on the papanicolaou examination to completely rule out carcinoma.

DR. THOS. HUGHES: Three months patient delay.

Case 30: A 65 year old, obese female, Para XV, had vaginal bleeding three weeks before admittance to hospital. A week before (two weeks after bleeding occurred) she was examined by a gynecologist. Examination revealed a clean cervix, slightly enlarged uterus, freely movable, and no visible vaginal discharge. No pelvic masses. An endometrial biopsy was reported as "red cell clots containing mature endometrium." Admitted for dilatation and curettage with suspicion of endometrial polyps vs. carcinoma. Pathology report was: Low grade adenocarcinoma of the endometrium, Clinical Stage I. Irradiation with 6200 mc. of radium. Hysterectomy advised, but patient refused. Ninety days post-operative, pelvis appeared normal.

Comment: DR. RUPPERSBERG: Delay minimal.



A Case Record

From The University Hospital,
Columbus, Ohio

Edited Under the Auspices of the Ohio Society of Pathologists

Philip Wasserman, M. D., President

Presented by J. M. Ryan, M. D., and Emmerich von Haam, M. D.

Edited by Dr. von Haam

PRESENTATION OF CASE

THIS 59 year old white male was admitted in a confused and lethargic state. The only history available was that given by the patient and its reliability must be questioned. The patient stated that he had been feeling quite poorly for the past month, during which time he had experienced extreme weakness, generalized malaise, polydipsia and a 20 pound weight loss. He denied strenuously polyuria and polyphagia. He complained of frequent indigestion during this period, with anorexia and nausea but no vomiting.

During the week prior to admission he had noted soreness in the right ankle and lower leg. He felt that he had had some fever during this period but denied having any chills. He had had no previous serious illnesses or operations. The familial history was noncontributory.

PHYSICAL EXAMINATION

The blood pressure was 140/90, respirations 32, pulse 120, temperature 101°F. The patient was a well developed, well nourished white male who seemed confused and lethargic; his speech was quite thick but the patient apparently was reasonably well oriented. The head, ears, nose, throat, conjunctivae and sclerae were normal. The pharynx was injected, the mucous membranes dry. The lingual papillae were quite hypertrophied and the tongue was quite dry. The neck was supple.

Examination of the chest revealed tachypnea of 32 per minute; the respiratory efforts seemed quite deep. The lungs were clear to percussion and auscultation except for a few scattered rhonchi. There was a moderate increase in the antero-posterior diameter of the chest. The heart had a normal sinus rhythm, no apparent cardiomegaly; the heart tones were faint. The abdomen was obese. The liver was palpated 1 to 2

fingerbreadths below the right costal margin. No other masses or organs were palpable.

The lower right leg and ankle were quite swollen, red and tender on palpation. There was increased warmth over this area. The skin of both lower legs showed increased pigmentation and evidence of old healed ulceration. The pulses of both dorsalis pedis arteries were present and equal. There was slight edema of the left ankle with no evidence of inflammation. Neurological examination revealed the deep tendon reflexes present but hypoactive bilaterally. The cranial nerves were intact and no pathologic reflexes could be elicited.

LABORATORY DATA

The admission urinalysis showed a specific gravity of 1.017, pH of 5, protetin 20 mg., sugar 3 plus, acetone 2 plus, diacetic acid negative; 4 to 7 hyaline casts were noted per high power field, and many white blood cells and 2 plus bacteria were also present.

The admission blood count showed a hemoglobin of 13 Gm., red blood cells 4.8 mil., white blood cells 28,200 with 86 per cent neutrophils (16 per cent nonsegmented) and 14 per cent lymphocytes. A repeat blood count done on his second hospital day was reported as showing 22,400 white blood cells with 97 per cent neutrophils (5 per cent nonsegmented) and 3 per cent lymphocytes. A white count done three days later was 22,700 with 92 per cent neutrophils (40 per cent nonsegmented) and 8 per cent lymphocytes.

SUGAR

Throughout his hospital course the patient's urine sugar was quite labile. The urinary acetone, strongly positive at the time of admission, rapidly dropped to 1 plus, and the urine was acetone-free on the first hospital day. However, during the second and third hospital days the pa-

Submitted August 16, 1956.

tient again began to spill 4 plus sugar with 3 plus acetone. The blood sugars went from an initial value of 490 mg. to 84 to 233, and 1 day prior to demise was 340 mg. The CO₂ combining power was 33 vol. on admission and 2 days prior to demise was 39 vol. The blood urea nitrogen was 28 mg. Serum electrolytes were: sodium 134, potassium 5.5, chlorides 105 mEq.

An electrocardiogram taken on the day prior to the patient's demise was interpreted as showing a probable old anterolateral myocardial infarct.

HOSPITAL COURSE

Shortly following admission the patient was given intravenous fluids, antibiotics and insulin. His temperature quickly rose to 103°F. and fluctuated between 103° and 100°F. for the remainder of his hospital stay. He remained extremely lethargic and responded to therapy very poorly.

For a few days following the initial therapy he improved slightly, and a Progress Note during this time stated, "Excellent result to date, will correct infection and study G. I. and G. U. tracts after diabetic control is established." Shortly thereafter, however, on the sixth hospital day the patient went into deep coma, the blood pressure fell to 70/40, the pulse rose to 140 per minute, the patient vomited some dark brown fluid and expired in deep respiratory distress.

CLINICAL DISCUSSION

DR. J. M. RYAN: I am sure this case is full of sleepers, as one reads through it. It is not nearly as obvious and clear-cut as one would like, but then so many cases never are. This was a 59 year old man who came into the hospital and was dead in six days. From the hospital course I must confess that his death was somewhat unexpected. Apparently he had been confused and somewhat lethargic for a period of time. His recent history of malaise and a 20 pound weight loss accompanied by polydipsia fits with the laboratory results and represents a good history of diabetes. His frequent periods of indigestion, anorexia and nausea without vomiting also fit with diabetes.

The week before admission he had noted a sore right ankle and right lower leg with fever but no chills. On admission the blood pressure was reasonably normal for a 59 year old man. He had a fever of 101° and his tongue was dry—a significant sign of dehydration. The chest was clear but there was tachypnea and his breathing was quite deep, suggestive of the Kussmaul type of respirations observed in diabetic acidosis. The heart appeared normal to physical examination, but the liver was down a finger or two, which also fits with uncontrolled diabetes.

Another significant finding is the red, warm lower right leg and tender ankle. It certainly is a good history for diabetes with ketosis, and

that diagnosis was substantiated by the urinalysis, which showed 3 plus sugar and 2 plus acetone. In addition, however, the urine showed hyaline casts, many white cells, and 2 plus bacteria. I would much rather know what type of bacteria they were.

In addition he had a normal red count and 20,000 white cells with a tremendous shift to the left. His cell counts were probably not that high, because this man seemed fairly well dehydrated. Throughout his course his urine sugars were noted to be labile and the blood sugars were likewise. The values of the CO₂ combining power of his serum certainly did not speak for a very deep ketosis and one should certainly have been successful in pulling him through this degree of acidosis. His serum electrolytes were essentially normal and the blood urea nitrogen was only moderately elevated, which would be evidence against the presence of azotemia often found in a patient with diabetic ketosis and dehydration.

THE EKG

An electrocardiogram taken on the day prior to the patient's demise was interpreted as showing an old anterolateral myocardial infarct. However, there is no past history to suggest angina, infarction, or cardiac failure. During his hospital course he was given intravenous fluids, antibiotics and insulin, and for a few days he improved, which caused the optimistic Progress Note on his chart. Shortly following this the patient went into deep coma, his blood pressure fell to 70/40, the pulse went to 140. The patient vomited and expired.

I don't think there is any question but that his diabetes represents the central pivot around which his whole case revolves, and which was apparently unrecognized until he came into the hospital. His history, unreliable as it was, also gives us a clue that he had probably been having trouble for at least a month. Once you make the diagnosis of diabetes, then the sky is the limit almost as to what trouble these people can get into. So let us try to be logical and analyze the sequence of events from his admission to his death six days later.

We know he had ketonuria, mild acidosis, and sepsis. He had an acute cellulitis of the leg around the ankle, and in addition must have had severe renal infection as evidenced by the fact that his urine was never free of pus cells. Furthermore, the difficult control of diabetes also is encountered frequently in sepsis.

As you know, diabetics are quite prone to develop pyelonephritis, but in addition they are also prone to develop a necrotizing papillitis. Would this diagnosis fit here? I don't like it for a number of reasons. People with necrotizing papillitis usually have a great deal more renal insufficiency than this man showed. Their blood urea nitrogen

is usually up in the hundreds, and in addition to white cells they have showers of red cells in their urine, which many times actually appears bloody. Although it is a possibility to be kept in mind, I don't think that this is necrotizing papillitis but rather a fulminating acute pyelonephritis. I think that the source for his renal disease may well have been the cellulitis of the leg, which seeded the blood stream with the organisms.

Once you raise the possibility of septicemia one wonders what had this to do with the man's demise? Before the days of penicillin and in its early days when it was not available in such astronomical doses, overwhelming sepsis was a very common cause of shock, which was usually fatal. He received penicillin and streptomycin in about 1,200,000 units a day, which is probably not the adequate dose for a case like this. You might want to give him 1,000,000 units every two to three hours. This depends upon the type or organism, however. We could never find out what type of organism this was since his illness was too brief to wait for the blood cultures.

FAILURE

In spite of all heroic therapy his sepsis was never controlled. He never was without fever or overwhelming leukocytosis, pyelonephritis and cellulitis. I don't question that this man died in shock. He developed a sudden and severe hypotension with tachycardia and died shortly thereafter. His blood pressure dropped during a single night, and although the patient was not as closely watched as he could have been, we know that overwhelming sepsis picks its own time to proceed into shock. Even the nurses' notes are sometimes of no help in learning exactly when this transition takes place and death approaches.

There are two other possibilities which could explain his rather sudden and unexpected demise. I do not think that the terminal vomiting of coffee-ground material means much. This is so frequently observed in dying people that it is of little diagnostic help. However, since he had an old myocardial infarct by electrocardiogram, one must raise the question of a second infarct as the cause of death. We know that his blood sugar was fluctuating between 390 and 84. Could he have gone into hypoglycemia and had a fresh myocardial infarction? This is possible, although it seems rather unlikely. There was no chest pain and no severe dyspnea, and although we know that people can have myocardial infarcts without pains, they always show dyspnea before they go into shock and die. I think that from a statistical point of view this possibility is worth mentioning, but I consider it rather unlikely.

SHOCK?

However, we have a good nidus for thrombophlebitis of his affected leg with resultant

pulmonary infarction. This man seems a good candidate for pulmonary infarction, since he has been lying in bed and probably has coronary disease with a sluggish blood stream. So I think the problem finally comes down to: Did he die in shock from an overwhelming sepsis, or did he have a fatal pulmonary infarct? Frankly, that is a hard decision to make when you walk in and find him taking his last breath.

The protocol states that he expired in deep respiratory distress. That could well fit with pulmonary infarction, which I find so frequently in people with heart disease, and although they really should be in cardiac failure, they don't have to be. We don't think often enough of this possibility, although our pathologist friends invariably admonish us, "Don't you ever think of pulmonary infarction?"

I would like to rest my case with the clinical diagnosis of diabetic ketosis, cellulitis of the right leg, overwhelming sepsis with severe pyelonephritis, and I just wonder if a little sleeper of this case was not a pulmonary infarction from thrombophlebitis of his leg. I don't believe that he had a recent myocardial infarct, but that too must be admitted as a possibility. As you know, a diabetic at 59 has about 90 chances out of 100 of having significant coronary disease. In this case we have little evidence for a recent coronary incident and the diagnosis would have to be made on the basis of statistical possibility alone. So I think I rather favor pulmonary infarction due to massive pulmonary embolism, knowing full well that I might well be wrong in this assumption. Does anybody have any questions?

GENERAL CLINICAL DISCUSSION

MEDICAL STUDENT: You say this brown fluid he vomited before he expired is not significant?

DR. RYAN: Yes. Many patients you see die in agonal distress will bring up this brown liquid material, and it is not guaiac-positive. I don't know what it means, it is just so commonly seen when people die that I don't think one can attach any clinical importance to it. I don't believe that it means a massive gastrointestinal hemorrhage.

DR. HAMWI: Could the patient have died from acute adrenal insufficiency?

DR. RYAN: He sure could, and it is a good possibility as a consequence of an overwhelming sepsis. Adrenal insufficiency would drop the blood pressure to almost nothing. I presume you are talking about the Waterhouse-Friderichsen syndrome?

MEDICAL STUDENT: Do people who go into diabetic problem commonly complain of anorexia, nausea and vomiting?

DR. RYAN: Quite commonly. They can get tremendous gastric dilatation from severe atony

of the stomach. I still prefer a pulmonary infarct as agonal event.

DR. SCHIEVE: Didn't anybody look at his eyegrounds?

DR. RYAN: The eyegrounds could not be visualized.

CLINICAL DIAGNOSIS

1. Severe diabetes mellitus with ketosis.
2. Acute cellulitis of the leg with thrombophlebitis.
3. Septicemia.
4. Acute pyelonephritis.
5. Massive pulmonary embolus and infarction.

PATHOLOGIC DIAGNOSIS

1. Arteriosclerotic heart disease with:
 - (a) old infarct involving two-thirds of the septum and apex;
 - (b) recent thrombosis of left descending coronary artery.
2. Acute pulmonary edema.
3. Recent pulmonary infarcts.
4. Early nutritional cirrhosis of the liver.
5. Acute pyelonephritis.
6. Cellulitis of the right leg.
7. Diabetes mellitus (clinical).

PATHOLOGIC DISCUSSION

DR. VON HAAM: Gentlemen, I selected this case because it is one which you will encounter probably frequently in your practice. Here is a man who never complained, then feels a little sick with some nausea, fever and generalized weakness and six days later he is dead. We found that he had diabetes and an infection. But as Dr. Ryan predicted, that was not all that was wrong with him.

The body was that of a well developed, slightly obese, elderly white man. At the time we saw him the redness of his leg had disappeared, so it proved not to be gangrene. Apparently the penicillin had been effective as far as his cellulitis was concerned.

The heart weighed 400 grams. The left ventricle was distended and flabby. There was a large area comprising the anterolateral lower part of the left ventricle which was gray and thin and covered with a mural thrombus. The rest of the myocardium was pale red and soft. Two side branches of the left descending coronary artery showed an old occlusion. The myocardium in the central portion of the septum adjacent to the old infarct showed a slight gray mottling. All coronary arteries showed an advanced sclerotic process with narrowing of the lumen. The descending branch of the left coronary artery was completely occluded by a very recent thrombus. The aorta showed moderately severe arteriosclerosis.

Both lungs were extremely edematous and the right lung contained a small infarct. The liver

was small and nodular. He may have been drinking a little bit in his younger days. The stomach showed marked distention and contained blackish fluid. No bleeding ulcer was found. However, the mucosa was very congested and we feel that blood may have been oozing into the lumen. The kidneys were enlarged, pale and showed the well known grayish-yellow streaks of a very severe acute pyelonephritis. The brain weighed 1320 grams and showed grossly only edema.

MICROSCOPIC EXAMINATION

Sections through the old infarct showed extensive fibrosis replacing two-thirds of the thickness of the left ventricle. Section through the septum showed an acute ischemic change of the muscle fibers with necrosis and inflammation not yet established. While the old large infarct must have been from six months to one year old, I estimate that the recent ischemic area of the myocardium was probably only one to three hours old. The muscle fibers showed only increased eosinophilia and fine fat droplets. The occlusion of the descending coronary artery was also recent and the thrombus developed on top of an arteriosclerotic patch.

Sections through both lungs showed severe edema indicating that the patient may have been getting more fluid than his circulatory system could handle. This acute pulmonary edema explained best the severe cyanosis, the respiratory distress and his death. There were also small recent infarcts in both lower lobes. Sections through the liver showed a nutritional type of cirrhosis.

PANCREAS

The pancreas showed no morphologic changes of the islands. From this we may conclude that the diabetes of the patient was the result of a relative insulin deficiency as we observe in obese individuals between 50 and 70 years old. If they go on a diet and lose their excess weight the diabetes markedly improves or even disappears completely. I also think that his diabetes was not very severe or of long duration. The kidneys showed microscopically a very severe and acute pyelonephritis and one kidney contained an infarct.

In summarizing these findings we may state that this patient was suffering from diabetes, septicemia and coronary heart disease and that clinically the first two conditions completely overshadowed the last one. I think also that his coronary disease was the reason why this patient died so unexpectedly in spite of the improvement in his diabetes. We had an inkling of his heart condition from the evidence of his previous infarct, but even Dr. Ryan, although he thought of the possibility, did not really consider coronary occlusion very seriously. The infarcts in his lungs and kidneys can be explained by emboli from his mural thrombus. The veins of his legs

were not explored. It is my opinion that this patient, while improving from his diabetes and his severe infection, suffered a severe coronary occlusion which killed him nearly instantaneously.

GENERAL DISCUSSION

DR. RYAN: I just wonder if the infection was not the most important event in this case. I would like to take this stand, because the diabetes was so difficult to control, which is rather typical for an infection in a diabetic. This man had been suffering from diabetes for about a month. The infection did not really become manifest until about a week before he died. I don't know how one could make the diagnosis of acute myocardial infarction in this case except on a probability basis.

DR. VON HAAM: If you had suspected myocardial disease would you have treated him differently?

DR. RYAN: I think that he should have had anticoagulants. Certainly, knowing he had a myocardial infarct, one would not want to give him inordinate amounts of fluid, and because of his stupor he is not going to tell you that he was as short of breath as the average person would.

MEDICAL STUDENT: Is Dr. von Haam saying that this man had a fresh infarct when he came into the hospital?

DR. VON HAAM: No. He died from an acute coronary occlusion which had not yet produced an infarct. The attack came when his blood pressure fell to 70/40 on the same day when this remarkable statement of clinical improvement appeared in his chart.

DR. RYAN: I wonder if one could argue that his pulmonary infarct caused the drop of his blood pressure and thus produced a secondary coronary occlusion?

DR. VON HAAM: Well, yes, if you believe that a small pulmonary infarct can cause a coronary thrombosis.

Special Ambulation Problems Of the Hemiplegic Patient

The hemiplegic patient may have special problems in passing either persons or objects. Wide experience has shown that the severely handicapped hemiplegic has to be taught to avoid objects which, or persons whom, he encounters on his sound side, since he is prone to fall toward the hemiplegic side whenever he meets such obstacles. He should either stand still until he is passed by the approaching person; or make a wide circle around the stationary object. The effect of strong unilateral visual stimuli upon the patient's sense of the position of his body in space is now under investigation.—Mieczyslaw Peszczyński, M. D., Cleveland: *Arch. Phys. Med. & Rehabil.*, 634-639, October, 1955.

KEEPING UP WITH MEDICINE

• BACKACHE is one of the most frequent of all symptoms encountered in women patients and the one most apt to be misinterpreted according to the Novaks.

* * *

• PROPERLY FITTING shoes, the reduction of overhanging mass of abdominal fat, proper mattress and springs, resting of tired muscles, are some of the measures indicated as appropriate for patients with backaches.

* * *

• MYCOTIC VULVITIS is often nowadays an aftermath of antibiotic therapy and may be spread to produce an eczema of the ear and "house-wife hands."

* * *

• WE ARE BEGINNING to have respect for the radiation hazard. In our promiscuous use of the x-ray and our ignorance of atomic radiation we forget that the mutations which we are today producing in future generations—our grandchildren and theirs—may well destroy the race. At any rate, it has more of a chance than do wars to do so.

* * *

• ANTIMETABOLITES are receiving an increased amount of attention and study. These substances have chemical structures so like that of an essential nutrient, vitamin, et cetera that they are accepted by the cell and by this competition make it impossible for the cell to use that essential, and so a deficiency disease is created. Recently an antimetabolite for methionine has been reported as occurring naturally.

* * *

• SURVEYS of children's food habits continue to come in, suggesting that only about one-third of our children are getting an adequate diet. It is high time that the American families go back to a substantial breakfast.

* * *

• STUDIES on the relationship of food intake to the capacity for hard work indicate that there is a dramatic decrease in endurance as a physiological response of the body to starvation.

* * *

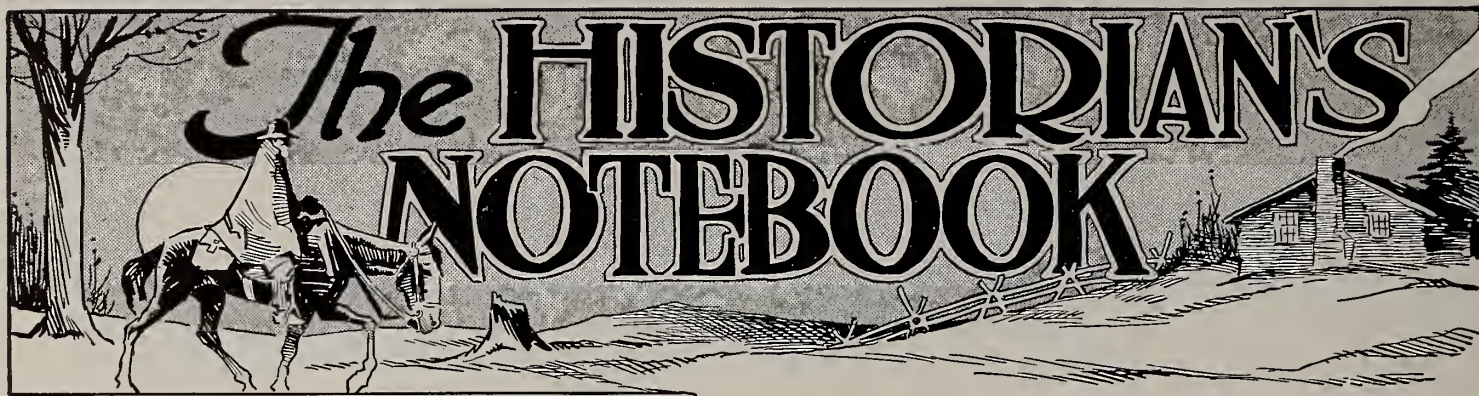
• OUR KNOWLEDGE of viruses is still fragmentary in spite of the fact that more than 40 virus diseases are known including many of major importance such as poliomyelitis and the common cold.

* * *

• THE TUBERCULIN test is of the greatest importance. One distinguished authority believes that without its continued use the eradication of tuberculosis will be impossible.

* * *

• IN GREAT BRITAIN, it is reported that there are only 317 known drug addicts and that the traffic is extremely limited.—J. F.



A Chronological Review of Ohio's Enviably Medical Record

Part II—The Second Seventy-Five Years

LINDEN F. EDWARDS, Ph. D.

PART I under this same title appeared in this Journal in the May, 1955 issue (51: 453-456). It included a list of medical and dental "firsts" which transpired in Ohio between the years 1788 and 1879. The present article is a compilation of outstanding events which occurred in the field of medicine and the allied professions in Ohio or by Ohioans from the latter date up to and including the year 1953. Thus Parts I and II represent an attempt to review the record of Ohio physicians and dentists during the first 150 years of statehood.

No claim is made that the list is complete notwithstanding a conscientious effort to make it as complete as possible. The task of compiling examples of medical and dental "firsts" transpiring in Ohio during the past quarter-century has been especially difficult and was approached with considerable trepidation due to the realization that any omissions from the list of contributions by contemporary Ohio physicians and dentists would very likely offend those involved. If such omissions have occurred apologies are hereby offered.

No concerted effort has been made to include in this chronological review the many notable contributions to the health professions by former Ohioans residing and practising in other states. Such a project is being contemplated for sometime in the future and will entail considerable research. The author, therefore, will greatly appreciate any information bearing upon this subject.

1882. Willoughby D. Miller, D.D.S., of Alexandria, was the first investigator to demonstrate the bacteriological origin of dental caries (*Dental Cosmos*, 49:1010, 1907).

1883. Jonathan Taft, D.D.S., of Cincinnati, was elected the first president of the National Association of Dental Examiners (Dalton, Van

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B.: *The Genesis of Dental Education*, 1946, p. 196).

Dr. Albert M. Bleile, M.D., of Columbus, was appointed to the chair of Experimental Physiology in Starling Medical College, the first such appointment west of the Allegheny Mountains (Seymour, R. J.: *The Ohio State University College of Medicine, A Collection of Source Material Covering a Century of Progress, 1834-1934*, p. 558).

1884. Dr. Willoughby D. Miller, D.D.S., was the first American citizen to receive a professional appointment in a German University, having been made professor of Operative Dentistry in the newly created Dental Department of the University of Berlin (*Dental Cosmos*, 49:1010, 1907).

Total gastrectomy was first attempted in America by Phineas Conner, M.D., of Cincinnati (Friedell, M. T. and Walters, W.: *Am. J. Surg.*, 51:66-78, Jan. 1941).

The first gastroenterostomy in America is credited to Dr. Joseph Ransohoff of Cincinnati (Friedell and Walters, loc. cit.).

The Ohio State Board of Pharmacy was created by an Act of the Legislature (*The Ohio Hundred Year Book*, 1901, p. 376).

Dr. Henry A. Smith, D.D.S., of Cincinnati, was elected the first secretary of the National Association of Dental Faculties, now the American Association of Dental Schools (Dalton, loc. cit., p. 136).

The first training school for nurses was established in Cleveland at the Huron Road Hos-

Submitted August 17, 1956.

pital (Rodabaugh, M. J.: *Ohio State Arch. & Hist. Quart.*, 61:344, 1952).

Dr. John W. Wright, of Columbus, performed the first operation in America for the extraction of cataract by expression (Forman, Jonathan: *The Ohio State University College of Medicine, A Collection of Source Material, etc.*, 1934, p. 516).

1885. Dr. Joseph P. O'Dwyer, of Cleveland, published an account of a successful method of intubation of the larynx in diphtheria (Stevenson and Guthrie: *History of Otolaryngology*, 1949, p. 87).

1886. Dr. J. Randolph Hall, of Ashtabula County, performed the first appendectomy in the United States (Cope, V. Z.: *Pioneers in Acute Abdominal Surgery*, 1940, p. 98).

The Ohio State Board of Health was created by legislative action (*Ohio Laws*, vol. 82, p. 77).

1889. Dr. James F. Baldwin, of Columbus, performed the first Porro cesarian section in Ohio (Palmer, D. W.: *Ohio State M. J.*, 39:358, 1943).

1890. Dr. James F. Whittaker, of Cincinnati, was the first physician in the United States to use Koch's tuberculin serum (Whittaker, Alfred H.: *Ohio State M. J.*, 50:142-146, Feb. 1954).

1891. Dr. John Jacob Abel, who was born on a farm near Cleveland, was appointed to the first professorship of Pharmacology at the University of Michigan and in the United States (*J. Pharmacol. & Exper. Therap.*, 67:373, Nov. 1939).

1892. The Ohio State Board of Dental Examiners was created by an Act of the Legislature (*The Ohio Hundred Year Book*, 1901, p. 361).

1893. Dr. W. J. Conklin, of Dayton, performed the first successful splenectomy in Ohio (Palmer, loc. cit., p. 447).

The first hospital in the world for Epileptics supported by public funds was founded at Gallipolis (Fetterman, J. L. and Horrocks, J.: *Ohio State Arch. & Hist. Quart.*, 58:379, 1949).

1894. J. R. Callahan, D.D.S., of Cincinnati, reported a new technique for opening dental root canals with sulphuric acid (*Bull. Ohio State Dent. Soc.*, 5:112, 1931).

Dr. David I. Wolfstein, of Cincinnati, was the first to teach hematology in an Ohio medical college (Kagan, S. R.: *The Modern Medical World*, 1945, p. 67).

1895. Dr. Levitt E. Carter, of Dayton, invented several electric dental appliances, including an electric oven, an electric casting device and the electric method of annealing gold and fusing platinum (*Dental Summary*, 34:1002, 1914).

Harvey Cushing, of Cleveland, while serving an externship at the Massachusetts General Hospital made the first anesthesia records in the

United States (*Surg., Gynec. & Obst.*, 71:689, 1940).

1896. Dr. Louis P. Bethel, D.D.S., M.D., Professor of Dentistry at Western Reserve University School of Dentistry, edited and published a dental journal entitled *Information*, which was the first dental publication devoted to oral hygiene (*Biographies of Prominent Dentists*, p. 16. Compiled by the students of Dr. W. C. Graham, the College of Dentistry of The Ohio State University, 1933).

The Ohio State Board of Medical Registration and Examination was established by legislative action (*The Ohio Hundred Year Book*, 1901, p. 370).

Dr. F. A. Korrell, of Belmont County, described for the first time in this country Glandular Fever as a specific disease entity (*Reference Handbook of the Medical Sciences*, vol. 8, p. 524, 1908).

Dr. George Crile, of Cleveland, was the first surgeon in America to use the x-ray in surgical practice (Crile, George: *An Autobiography*, vol. 1, p. 76, 1947).

Dr. Lewis M. Early, of Columbus, the first physician of that city to specialize in Radiology, exhibited a series of radiographs at the Annual Meeting of the Ohio State Medical Society demonstrating the medical application of "the new science" (Brown, Percy: *American Martyrs to Science Through the Roentgen Ray*, 1936, pp. 106-110).

1897. The Cincinnati Board of Health adopted a resolution requiring physicians of that city to report all cases of tuberculosis, an action believed to antedate similar action elsewhere in the United States (*Ohio Pub. Health*, 11:9, 1947).

Dr. George Crile reported a new method for producing surgical anesthesia by blocking the main nerve trunks to the operative area (Palmer, loc. cit., p. 557). In this same year he performed the first amputation ever done under cocaine anesthesia (*Autobiography*, vol. 1, p. 80) and performed the first bloodless operation ever performed on the head and neck by temporarily closing both carotid arteries by means of artery clamps of his own design (*ibid.*, p. 63).

1898. The Ohio State Board of Health Laboratory was established in Columbus (Platter, H. M.: *Ohio State Arch. & Hist. Quart.*, 57:396, 1948).

Dr. J. D. Lower, of Cleveland, did the first thigh amputation ever performed under spinal block anesthesia (Crile, *Autobiography*, vol. 1, p. 109).

Dr. James F. Baldwin removed a knife blade from the lung, the first successful attempt in America of removing a foreign body from the lung by external incision. (Baldwin, J. F.: *Surgical Papers*, 1932, p. 50).

1899. The first meeting of the American

Proctologic Society was held in Columbus on June 6 and 7 of this year (*Columbus Medical Journal*, 23:29, 1899).

Dr. David Tod Gilliam, of Columbus, performed the first operation in the United States for round ligament ventro-suspension of the uterus (*J. Obstetrics*, 41:299, 1900).

Dr. Weston Price, of Cleveland, was one of the first if not the first dentist in America to apply the x-ray to the practice of Dentistry (*Bull. Ohio State Dent. Society*, 7:168, 1933).

1900. Grant Hospital of Columbus was erected, at which time it was the largest private hospital in the world (Baldwin, J. F.: *Surgical Papers*, p. 49).

1901. The Ohio Society for the Prevention of Tuberculosis was organized, the first voluntary organized association for popular health education in the world (Paterson, R. G.: *Ohio State Arch. & Hist. Quart.*, 55:311-337, 1946).

1904. Dr. Albert H. Freiberg, of Cincinnati, devised an improved apparatus for treatment of deformity of hip-joint disease using weights and pulley extension (Kagan, S. R.: *American Jewish Physicians of Note*, 1942, p. 252).

Dr. J. F. Baldwin reported an operation he devised for the formation of an artificial vagina by intestinal transplanation (*Ann. Surgery*, 40:398, 1904).

1905. The Ohio Association of Medical Teachers was organized in Columbus (Transactions of the Association, 1905).

The Ohio State Medical Journal was established (Forman, Jonathan: *Ohio State M. J.*, 43:632, 1947).

Dr. Casper H. Benson, of Columbus, opened a hospital for the treatment of tuberculosis, at that time an entirely new concept (*The Columbus Citizen*, May 11, 1952).

1906. The Ohio State Dental Library was established in the Columbus Public Library, the first dental library in the world to be housed in a public library building (*Bull. Ohio State Dent. Soc.*, 1:24, 1927).

1907. Dr. George W. Crile for the first time in medical history furnished proof that blood transfusion is a safe method of treating shock (*Cleveland M. J.*, 6:112, 1907). He also described a practical technique of cuffing an artery over a canula in the human, this being the first effort to render blood transfusion comparatively popular (*Bull. Med. Research*, 9:6, 1955).

Dr. Elmer I. McKesson, of Toledo, introduced the practice of taking blood pressure during the administration of general anesthetics (Lundy, *Clin. Anesthesia*, 1942, p. 712). He and Dr. C. T. Teter developed new methods of controlling concentrations and to improve rebreathing techniques

(Leake, C. D.: *Letheon—The Cadenced Story of Anesthesia*, 1947, p. 105).

Dr. Alfred Friedlander, of Cincinnati, was the first to report a case of enlargement of the thymus treated by x-rays (Kagan, S. R.: *Jewish Medicine*, p. 318).

1908. Dr. Frederick Forchheimer, of Cincinnati, described Forchheimer's sign, a reddish eruption on the soft palate in rubella (Kagan, *Am. Jewish Physicians of Note*, p. 252).

1909. Dr. Howard Taylor Ricketts, a native of Findlay, discovered the causative organism of Rocky Mountain spotted fever (Haagensen, C. D., and Lloyd, W.E.B.: *A Hundred Years of Medicine*, 1943, p. 100).

Dr. Samuel Iglauer, of Cincinnati, pioneered in the study of diseases of the mastoid by means of x-rays (Kagan, *Am. Jewish Physicians of Note*, p. 253).

1910. Dr. Crile announced the principle of balanced anesthesia, which he called Anoci-association (Clement, *Nitrous Oxide-Oxygen Anesthesia*, 1951, p. 31).

Dr. Howard Taylor Ricketts discovered the cause of typhus fever (Haagensen and Lloyd, loc. cit., p. 100).

The first free dental clinic for children in this country was opened in Cincinnati (*Bull. Ohio State Dent. Soc.*, 4:178, 1935).

1911. Dr. Elmer I. McKesson described a new apparatus for improving the efficiency of anesthetic administration (*Surg., Gynec. & Obst.*, 13:456-462, 1911) and introduced a method of fractional breathing during the administration of nitrous oxide anesthesia (Clement, loc. cit., p. 31).

Dr. James M. Phillips, of Columbus, opened the Pasteur Institute, the first in Ohio and the second in the United States (*Columbus*, published by the Pen and Pencil Club, 1915, p. 45).

1912. Dr. Frank H. McMechan, of Cincinnati, was largely instrumental in organizing the American Association of Anesthetists (Leake, loc. cit., p. 106).

Dr. Harvey Cushing, a native of Cleveland, published the first clinical monograph ever published on the subject "The Pituitary Body and its Disorders" (*A Bibliography of the Writings of Harvey Cushing*, 1939, p. 11).

1913. Homer C. Brown, D.D.S., of Columbus, was the first dentist in the United States to be appointed a member of a State Board of Health (*Who's Who in Dentistry*, 1925, p. 34). This year the National Dental Association was reorganized and the name changed to the present American Dental Association, Dr. Brown having the distinction of being its first president (*Biographies of Prominent Dentists*, loc. cit.).

(To be concluded in December issue.)

Mental Hygiene . . .

Dr. Porterfield Resigns To Accept Post in Washington; Successor Is Named as Is Mental Hygiene Commissioner; Advisory Council Created

SEVERAL developments have been announced within recent weeks in the Ohio Department of Mental Hygiene and Correction.

Dr. John D. Porterfield, director of the Department since its separation from the Welfare Department in 1954, resigned to accept a Washington post in the U. S. Public Health Service.

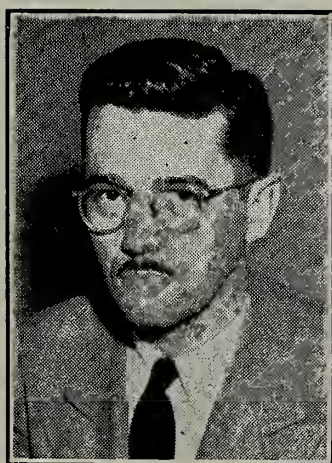
Dr. C. Earl Albrecht, assistant director of the Department since February of this year, was named acting director by Governor Frank J. Lausche.

Dr. Leonard P. Ristine, acting commissioner of Mental Hygiene since July, 1955, was named commissioner by Dr. Porterfield before he left. As commissioner he is chief of the Division of Mental Hygiene, a branch of the Department of Mental Hygiene and Correction.

An advisory council to aid the Ohio Department of Mental Hygiene and Correction in planning its long-range building program has been created, and 19 persons named to serve on the council.

OUTSTANDING CAREER

Dr. Porterfield left after an outstanding career in Ohio, first as director of the Ohio Department of Health and later as director of the Department of Mental Hygiene and Correction.



DR. PORTERFIELD

He has accepted a post as an assistant surgeon general in the U. S. Public Health Service in Washington, D. C. In his new capacity he will have "service-wide responsibility for planning and developing new programs for providing a continuous approval and evaluation of existing activities and for advising on proper balance among the various programs of the service."

In the higher echelon of the U. S. Public Health Service there is a surgeon general, a deputy surgeon general and four assistant surgeons general.

Before coming to Ohio, Dr. Porterfield had been with the U. S. Public Health Service for 11 years, holding the rating of senior surgeon, a rank equal to that of lieutenant colonel in the Army. He was appointed director of the Ohio Department of Health in 1947 by then-Governor Thomas J. Herbert. He was re-appointed to the same post by Governor Lausche in 1952 and in

1954 was named by Governor Lausche to head the Department of Mental Hygiene and Correction.

DR. ALBRECHT

Dr. Albrecht came to Ohio last February from Juneau, Alaska, where he was the territory's first full-time commissioner of health. A graduate of Jefferson Medical College in 1932, Dr. Albrecht did residency work in surgery and went to Alaska in 1935. During the war, he was chief of surgery and commanding officer of the U. S. Army 600-bed hospital at Fort Richardson, Alaska.

DR. RISTINE

Dr. Ristine, after filling the post since June, 1955, as acting commissioner, was named commissioner—one of the State's top-salary positions, paying \$22,500 a year. He has been with the Division of Mental Hygiene in Ohio since March, 1955.

Dr. Ristine came to this state from Austin, Texas, where he was superintendent of the state hospital. He was executive consultant to the Kansas Board of Institutions in 1952 and 1953 and prior to that was superintendent of the Topeka, Kansas, state hospital.

A graduate of the University of Iowa College of Medicine in 1924, he is a diplomate of the American Board of Neuropsychiatry and is on the Mental Hospital Committee of the American Psychiatric Association.

During World War II, Dr. Ristine served with the Air Corps and Ground Forces and attained the rank of Lieutenant Colonel.

ADVISORY COUNCIL

An advisory council to aid the Department of Mental Hygiene and Correction in the planning of its long-range building program was created by Dr. Porterfield late in September, with the approval of the Governor.

Appointed to the council by Dr. Porterfield are 18 nationally prominent consultants in the fields of mental hygiene, adult correction and juvenile retraining and one layman.

In announcing creation of the council Dr. Porterfield said:

"Ohio is undertaking the most ambitious building program in its history as regards mental hygiene facilities, prisons and institutions for problem juveniles. With \$75,000,000 available for this purpose from the bond issue approved last November by the voters of Ohio, plus additional millions from general appropriations, it is essential that we avail ourselves of the best

thinking in determining the wisest use of these funds to insure the greatest good for the greatest number."

Members of the council are:

Myrl E. Alexander, New York City, president of the American Correctional Association;

Dr. Robert C. Anderson, manager of the Topeka Veterans Administration Hospital;

Dr. Percival Bailey, Chicago, superintendent of the Illinois State Psychopathic Institute;

Dr. Walter E. Barton, superintendent of the Boston State Hospital;

Dr. Wendell A. Butcher, superintendent of the Columbus State School;

Dr. D. Ewen Cameron, Montreal, chairman of the Department of Psychiatry at McGill University, and director of Allan Memorial Institute;

E. R. Cass, New York City, general secretary of the American Correctional Association;

Dr. Edward D. Greenwood, Topeka, coordinator of children's services for Kansas institutions and member of the executive committee in child psychiatry of the Menninger School of Psychiatry;

Alston G. Gutterson, Washington, D. C., representing the mental hospital service architectural study project of the American Psychiatric Association;

Dr. Edward N. Hinko, superintendent of the Cleveland Receiving Hospital and State Institute of Psychiatry;

Charles F. Kettering, Detroit, well-known physicist and research expert, who has contributed much to his native Ohio;

Dr. Maurice Levine, director of the Central Clinic, Cincinnati General Hospital;

Austin MacCormick, Berkeley, professor of criminology at the University of California;

Dr. William Malamud of the Boston University School of Medicine;

Dr. Morris F. Mayer, Cleveland, resident director of Bellefaire;

Dr. Benjamin Pasamanick, director of research at Columbus Receiving Hospital and State Institute of Psychiatry;

Dr. Ralph D. Rabinovitch, Northville, Mich., director of Hawthorn Center;

Joseph H. Reid, New York City, executive director of the Child Welfare League of America, Inc.;

Kenyon Scudder, Balboa Island, Calif., director of field services for the Osborne Association, Inc.

Aero-Medical Meeting to Discuss Jet-Atomic Flight Problems

Medicine in the jet-atomic age of flight will be the central theme of the 28th annual meeting of the Aero Medical Association at the Shirley Savoy Hotel, Denver, Colo., May 6-8, 1957.

Additional information may be obtained from Dr. E. J. Baldes, chairman, Scientific Program Committee, Mayo Clinic, Rochester, Minn.

Do You Know? . . .

Dr. H. T. Zankel, chief of physical medicine and rehabilitation at Crile Veterans Hospital, Cleveland, since 1946, is leaving Ohio to become chief of physical medicine and rehabilitation at the Veterans Hospital, Durham, N. C.

* * *

Dr. A. Ashley Weech, professor and director of the Department of Pediatrics, University of Cincinnati, was presented the American Academy of Pediatrics' 1956 Borden award, in ceremonies at the academy's meeting in New York City. Dr. Weech is medical director of the Cincinnati Children's Hospital and director of the hospital's research foundation.

* * *

Dr. Alan R. Moritz, professor of pathology at Western Reserve University, received the Walter Burdick Award for his contributions to legal medicine at the Chicago meeting of the American Society of Clinical Pathologists.

* * *

Dr. Jonathan Forman, Editor of *The Journal*, spoke before the recent meeting of the American Medical Writers' Association in Chicago on the value of workshops on medical writing at organization meetings. Dr. Forman was re-elected for a third term as chairman of the group's Advisory Council.

* * *

Dr. Edwin E. Ash is the new president of Springfield Kiwanis Club.

* * *

Dr. Walter J. Zeiter, Cleveland, was re-elected executive director of the American Congress of Physical Medicine and Rehabilitation at the recent meeting of that organization in Chicago.

* * *

Dr. John A. Ordway, instructor in psychiatry, and Richard Cosway, professor of law, were in charge of a series of courses on psychiatry and the law given by the University of Cincinnati and the Cincinnati Bar Association.

* * *

Dr. Leon Schiff, professor of clinical medicine in the University of Cincinnati College of Medicine, spoke on jaundice at the annual meeting of the Michigan State Medical Society in Detroit.

* * *

Dr. Donald M. Glover was honored at a testimonial dinner following announcement that he would retire from his post as director of surgery at St. Luke's Hospital in Cleveland, after 17 years in that position.

* * *

The American Society of Anesthesiologists, meeting in Kansas City, presented their distinguished service award posthumously to the late Dr. Rolland J. Whitacre, of Cleveland. Dr. Whitacre, an ASA past-president, died February 16.

General Practitioners . . .

Ohio Academy's Sixth Annual Session in Columbus Draws Excellent Attendance; Election of Officers and Other Key Persons Announced

THE OHIO ACADEMY of General Practice held the largest and one of the most successful annual session in its history, September 18-20, officers reported. The registration was 821 with 490 doctors, 123 guests, 21 medical students and 187 exhibitors.

The meeting was held in the new Franklin County Veterans Memorial Building in Columbus, where the technical and scientific exhibits included 70 booths. Nineteen guest speakers participated in the program, of which 10 were nationally known doctors from Boston, New York, Washington, D. C., Chicago, Atlanta, Jackson, Miss., Milan, Mich., and Rochester, Minn. The annual banquet and ladies luncheon at the Sheraton-Hilton Hotel, contributed much to the evening.

OFFICERS ELECTED

Dr. Roscius C. Doan, Miamisburg, succeeded Dr. James R. Jarvis, of Van Wert, as president. Dr. Earl C. Van Horn, Cincinnati, was chosen president-elect, to take office as president at next year's annual meeting which is scheduled for September 17-19, 1957, at the same building in Columbus.

Other officers and key persons in the organization were elected as follows: Dr. Howard R. Mitchell, Sr., Columbus, re-elected treasurer; Dr. Lewis W. Cellio, Columbus, speaker of the House of Delegates; Dr. Roger A. Peatee, Bowling Green, vice-speaker; Dr. Herbert W. Salter, Cleveland, delegate to the American Academy of General Practice; Dr. William J. Hartlage, Scioto County, alternate delegate.

The following district directors were elected or re-elected: Second District, Dr. Elliott W. Schilke, Springfield, (re-elected); Fourth District, Dr. Gwyn H. Smith, Toledo (re-elected); Sixth District, Dr. Gilbert C. Dowell, Canton (re-elected); Eighth District, Dr. Chester P. Swett, Lancaster (re-elected); and Tenth District, Dr. William P. Smith, Columbus.

RESOLUTION

One item of business of the day long session of the Academy's House of Delegates was a resolution adopted on a proposal to establish a national and constituent state chapter advisory committee on insurance problems. This resolution, to be sent to the March, 1957, annual meeting of the Congress of Delegates of the American Academy of General Practice, requests a committee be appointed to accomplish the following:

"1. To formulate a workable definition of the terms used by industry, insurance companies,

labor organizations, government and lay people such as 'complete package; complete medical care; complete physical examination; basic survey physical examination; routine office call; routine home call,' and

"2. To set the basic principles to be considered by the local chapters to arrive at a basic fee schedule, and in evaluating medical, surgical and hospitalization insurance programs dealing with labor, industry, social agencies, which concern the methods of coverage and costs of medical care which are acceptable to the American Academy of General Practice as a whole for its members.

"Further be it resolved that the State or constituent chapters set up a similar state committee to work and to assist the National Committee in coordinating the National program so that the same is made readily available for the assistance to local groups in each and every constituent chapter in dealing with these problems."

Propose Legislation To Outlaw Dangerous Chemicals

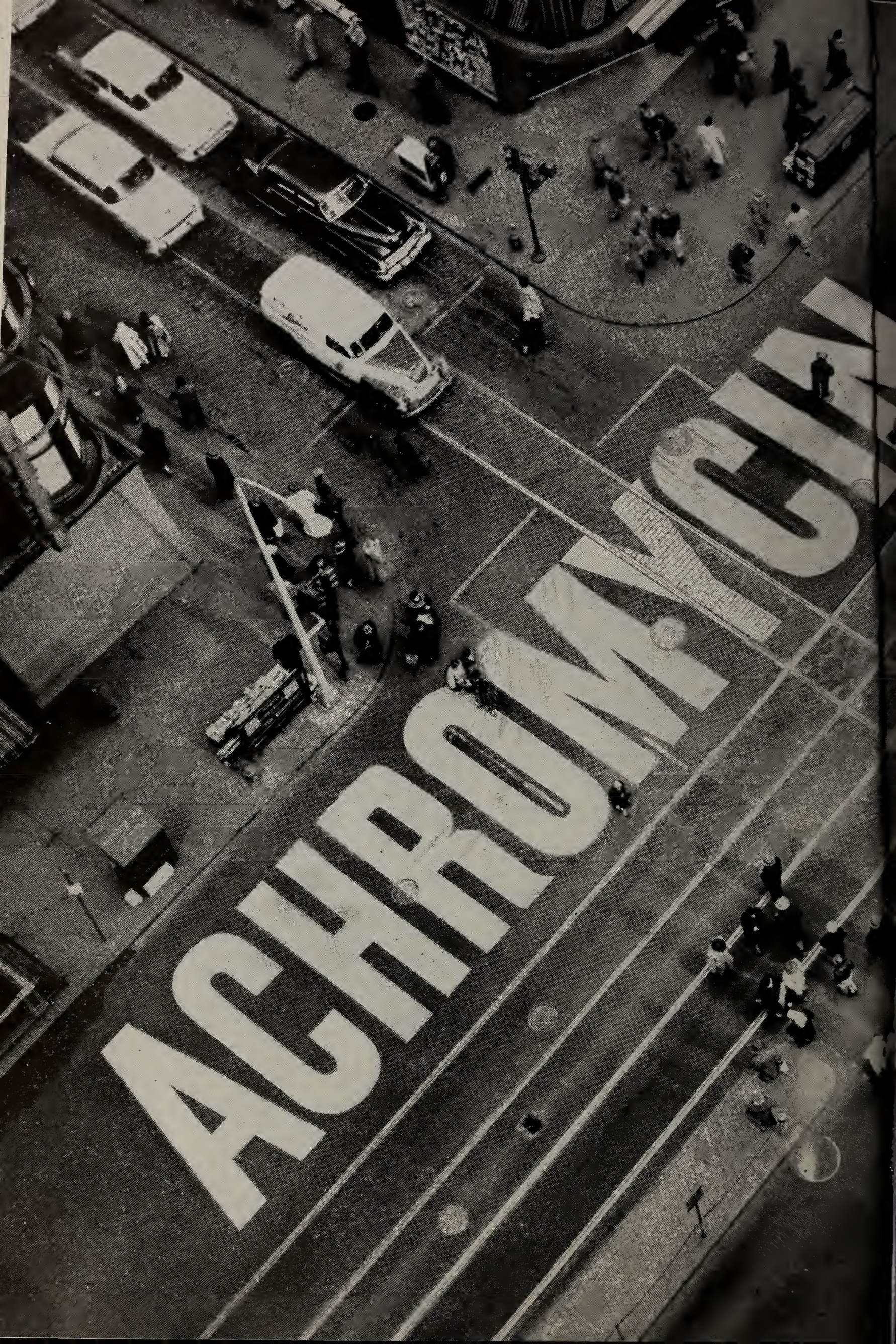
The AMA Board of Trustees has authorized the Committee on Toxicology to proceed with plans for the drafting of proposed legislation which would require labeling of dangerous household and commercial chemicals.

This action, said Committee Secretary Bernard E. Conley, was prompted by the growing need for model legislation requiring precautionary labeling of those chemical products considered potentially harmful. The Committee estimates that there are a quarter of a million different trade name substances currently on the market. It is virtually impossible for any physician to be acquainted with the toxic chemicals contained in all of these products.

One of the first steps in the Committee's work will be to consult interested organizations and individuals having a knowledge of the broad problem. Some of these organizations include the American Academy of Pediatrics, American Public Health Association, American Pharmaceutical Association, National Safety Council, leading trade associations and various state and national government regulatory agencies.

Purpose of the proposed legislation is to reduce careless and ignorant handling and storage of chemicals found in and around the home.

Any proposed legislation should require informative labeling on household chemical items, including listing of possibly harmful ingredients, their potentialities for harm, their directions for safe use, and first aid instructions for poisoning emergencies.





ACHROMYCIN*

Tetracycline Lederle

for prophylaxis and treatment of

obstetric infections

Posner and his colleagues¹ have reported on the use of tetracycline (ACHROMYCIN) in 96 cases of obstetric complications, including unsterile delivery, premature rupture of the membranes, endometritis, parametritis, and other conditions. They conclude that this antibiotic is ideally suited for these uses.

Other investigators have shown ACHROMYCIN to be equally useful in surgery and gynecology and virtually every other field of medicine. This outstanding antibiotic is effective against a wide variety of infections. It diffuses and penetrates rapidly to provide prompt control of infection. Side effects, if any, are negligible.

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ACHROMYCIN SF

ACHROMYCIN with STRESS FORMULA VITAMINS. Attacks the infection, bolsters the patient's natural defenses, thereby speeds recovery. Especially useful in severe or prolonged illness. Stress formula as suggested by the National Research Council.

SF Capsules, 250 mg.

SF Oral Suspension, 125 mg. per teaspoonful (5 cc.)

 For more rapid and complete absorption. Offered only by Lederle!

¹Posner, A. C., *et al.*; Further Observations on the Use of Tetracycline Hydrochloride in Prophylaxis and Treatment of Obstetric Infections, *Antibiotics Annual* 1954-55, pp. 594-598.



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Annual Meeting Schedule . . .

Outline of Events for 1957 Session, May 13-16, Columbus, Given Final Approval; All Scientific Sessions to be in New Memorial Building

GENERAL schedule of events for the 1957 Annual Meeting of the Ohio State Medical Association in Columbus has been completed by the Committee on Scientific Work and has been approved by The Council.

The meeting will be held on May 13, 14, 15 and 16, although the major part of the program will not open until Tuesday, May 14. Monday, May 13, has been set aside for meetings of specialty societies and medical groups. Actually the only OSMA meeting on Monday will be the first session of the House of Delegates.

The scientific meetings will be held in Columbus' new Veterans Memorial Building where the Scientific and Technical Exhibits also will be located.

Business sessions of the House of Delegates and social events will be at the Neil House. Activities of the Woman's Auxiliary will be at the Deshler-Hilton Hotel.

Following is a schedule of events for the four days which was set up by the Committee on Scientific Work after consultation with officers of the scientific sections:

MONDAY, MAY 13

Meetings of specialty societies and other medical groups.

6:00 P. M.

First Session of House of Delegates (dinner and business meetings), Neil House

TUESDAY, MAY 14

8:30 A. M.

Opening of Registration Headquarters

9:00 A. M.

Opening of Technical and Scientific Exhibits

9:30 to 11:00 A. M.

Section Sessions:

Surgery

Nervous and Mental Diseases

Physical Medicine

Otorhinolaryngology

Urology

Industrial Medicine

11:00 to 11:30 A. M.

Tour of Exhibits.

11:30 A. M. to 12:30 P. M.

Continuation of above section sessions.

2:00 to 3:00 P. M.

General Session:

"The Doctor and the Law"

(Panel of experts to handle varied questions in this field and questions from the floor.)

3:00 to 3:30 P. M.

Tour of Exhibits:

3:30 to 5:00 P. M.

General Session:

Symposium on Management of Automobile Injuries.

6:00 P. M.

Dinner by Council, Ohio State Medical Association, honoring past presidents and committee chairmen.

WEDNESDAY, MAY 15

8:30 A. M.

Opening of Registration Headquarters

9:00 A. M.

Opening of Technical and Scientific Exhibits

9:30 to 11:00 A. M.

Section Sessions:

Internal Medicine

Neurological Surgery

General Practice

Anesthesiology

Ophthalmology

Pediatrics

Radiology

11:00 to 11:30 A. M.

Tour of Exhibits.

11:30 A. M. to 12:30 P. M.

Continuation of above section sessions.

2:00 to 3:30 P. M.

General Session:

Three out-of-state guest speakers.

3:30 to 4:00 P. M.

Tour of Exhibits.

4:00 to 5:30 P. M.

General Session:

"The Doctor in Court"

(Presentation by members of the Legal Department of the American Medical Association)

tion, to be followed by a question and answer period.)

7:30 P. M.

Annual Banquet.

THURSDAY, MAY 16

8:30 A. M.

Opening of Registration Headquarters

9:00 A. M.

Opening of Technical and Scientific Exhibits

10:00 to 11:00 A. M.

General Session:

"Advice to Physicians on Investments"

"Advice to Physicians on Estate Planning"

11:00 to 11:30 A. M.

Tour of Exhibits.

11:30 A. M. to 12:30 P. M.

General Session:

"Persistent Diarrheas" (Panel discussion.)

12:00 Noon

Luncheon and final business session of House of Delegates.

2:00 to 2:30 P. M.

General Session:

"The Malpractice Problem"

2:30 to 3:00 P. M.

General Session:

"Oral Hypoglycemia Agents"

3:00 to 3:30 P. M.

Tour of Exhibits.

3:30 to 4:30 P. M.

General Session:

"Anti-Microbial Therapy in Special Fields."

Civil Defense Conference Scheduled in Chicago

The seventh annual conference of the County Medical Societies' Civil Defense Organization will be held in Chicago's Hotel Morrison, November 10-11.

The Conference will not only assist local groups with health and medical planning, but will provide representatives with an opportunity to discuss and exchange information of mutual interest and concern.

A Congressional committee recently concluded extensive public hearings on civil defense and, as a result, made many significant recommendations. The committee chairman, Congressman Holifield, has been invited to speak at the AMA conference.

The program calls for panel discussions and a symposium devoted to psychic reactions as they pertain to large-scale civilian attack.

Central Ohio Heart Association To Hold Fall Program

Dr. A. C. Corcoran, director of Cardiovascular research at the Cleveland Clinic and editor of the journal *Circulation*, will address the Scientific Council of the Central Ohio Heart Association at its fall meeting Friday, November 23, in Columbus. Dr. Corcoran will speak on "Management of Malignant Hypertension" at 2:00 p.m. in M-100 Starling Loving Hall, University Hospital, Ohio State University.

This all day program will convene at 10:00 a.m. with a movie entitled "Thrombotic and Embolic Phenomena." At 10:30 a.m. a panel will discuss "Intractable Congestive Heart Failure." Panelists will include: Drs. George I. Nelson, Columbus; Joseph M. Ryan, Columbus; A. C. Corcoran, Cleveland; M. H. Rosenblum, Steubenville; John Harley, Springfield.

Dr. Emmerich von Haam, chairman of the Department of Pathology, Ohio State University, will conduct a cardiac clinical pathology conference at 3:00 p.m.

The meeting will adjourn for lunch at the Jai Lai. In charge of the program will be Drs. Jack S. Silberstein, program chairman, R. H. Schoene, Wiley Forman, Robert Kirk, Philip B. Hardyman, and John Harley.

Blood Bank Management Course Scheduled

A course in "Blood Bank Management" is scheduled to be presented by the Frank E. Bunts Educational Institute, affiliated with the Cleveland Clinic Foundation November 15 and 16 at the Institute, 2020 East 93rd Street, Cleveland, for physicians and registered technicians.

Information and registration forms may be obtained from the Institute's registrar at that address.

Some Recent Articles On Civil Defense

Here are some recent articles in connection with civil defense of interest to physicians working in that field:

"Revised Instructions for Shipping Blood," TB-11-14, FCDA, Battle Creek, Michigan.

"Responsibilities for Production and Distribution of Potable Water During Disaster" (Revised), TB-11-10, FCDA, Battle Creek, Michigan.

"Minimum Potable Water Supply Requirements in Civil Defense Emergencies" (Revised), TB-11-16, FCDA, Battle Creek, Michigan.

"Mortuary Services in Civil Defense," TM-11-12, FCDA, Battle Creek, Michigan.

Dr. Benjamin Felson, Cincinnati, participated in the annual Winston-Salem (N.C.) Heart Symposium, speaking on x-ray diagnosis.

FIRST CALL FOR ENTRIES IN

Scientific and Educational Exhibit

1957 Annual Meeting, Ohio State Medical Association

May 14, 15, 16, Columbus, Ohio, 1957 .

OUTSTANDING among the features of the 1957 Annual Meeting of the Ohio State Medical Association, May 14, 15, 16, Columbus, Ohio, will be the Scientific and Educational Exhibit. It will be in the Main Exhibit Hall, Veterans Memorial Building, where all the scientific sessions of next year's meeting will be held.

The Committee on Scientific and Educational Exhibits which is in charge of this feature of the meeting consists of Dr. Geo. J. Hamwi, Columbus, Chairman; Dr. Harvey C. Knowles, Cincinnati; Dr. A. D. Nichol, Cleveland; Dr. Robert E. Zipf, Dayton; Dr. Edwin H. Ellison, Columbus. Members of this Committee may be contacted for information about the Exhibit.

Exhibit material should fall in one of three categories: Original investigation, teaching value, or special educational value to physicians. 

On the opposite page will be found an application blank. If you have material suitable for an exhibit send in an application. If you know of a colleague or group of physicians who have interesting material to display suggest that they do the same.

Cost of transporting exhibits to the meeting must be borne by the individual exhibitors as well as the costs of cards, signs, etc., which are a part of the exhibit. The Ohio State Medical Association will provide without cost to the exhibitor the following: Exhibit space, shelves, sign for booth, view boxes, current, furniture, decorations, etc., providing all items are approved in advance by the chairman of the committee. Watchman service will be provided for the exhibit.

Equipment and facilities similar to that used at A. M. A. meetings will be used. The accompanying picture shows the type of booth which will be provided.



Type of Booth To Be Used for Scientific Exhibits

Booths will be uniform color and design, solidly constructed of wood and wall-board and skirted with velour. A shelf will surround three sides with the upper area covered with taut blue crash fabric for bulletin board background. This material will permit the tacking or taping of charts and specimens without fear of damaging the exhibits. Fluorescent lights are a part of the background.

New OASI Disability Program . . .

Physicians Will Play Role of Examiner in This Program Much the Same As Under Disability Freeze; Same State Agency Will Administer Both

BEGINNING July 1, 1957, thousands of disabled men and women in Ohio, age 50 and over, will become eligible for Old Age and Survivors Insurance benefits under provisions of the Social Security Amendments of 1956—H. R. 7225. In fact, this program is now in progress since applications have been authorized beginning October 1.

For all practical purposes the new disability benefits provision of the Social Security program is merely an extension of the already established "disability freeze" which is being administered in Ohio through the Disability Determination Section of the Ohio Bureau of Vocational Rehabilitation. This same office will administer the new disability benefits program of the federal law.

Although no public funds are available under the program for physical examinations, physicians will play an important role in the new program, much the same as they are doing under the freeze provisions. Applicants under the program are obligated to furnish proof of disability, and any expenses involved in furnishing proof—such as physical examinations—must be borne by the applicant. The physician, therefore, should bill the patient for any fees due him as a result of the application.

In a very limited area the Disability Determination Section is permitted to secure medical consultations at government expense.

The new benefits program came right on the heels of disability freeze with its early influx of applications, retroactive in many cases to 1941. The Disability Determination Section is still working against a backlog of these applications. Since its creation in August, 1955, the office has received over 15,000 applications under the disability freeze, and has processed more than 10,000 of these. It is now processing more than 1,000 applications a month as against about 700 new cases a month coming in.

Under the new program it is estimated that the load will be about double what it has been in the past.

One of the difficulties the agency has faced has been in determining the status of a large number of disabilities that go back several years, sometimes as far as 1941. In all cases the level of severity of impairment at the alleged date of onset must be determined as well as the present level of severity.

SUPPORTING DATA NECESSARY

In this respect, James L. Wallace, supervisor of the Disability Determination office in Ohio, emphasized the necessity of physicians answer-

ing in detail the questions required on application Form OA-D 826.

The standards for establishing the level of severity which an individual must meet were set up by the Commissioner of Social Security, on advice from the National Medical Advisory Committee. The medical standards drawn up by the Medical Advisory Committee list the diagnostic and clinical findings that must accompany the diagnosis, such as x-ray, EKG, EEG, laboratory tests, etc. In other words, a mere statement from the examining physician that the applicant is permanently disabled cannot be accepted by the agency without the evidence of clinical findings to back it up.

As far as can be determined at present, the procedure for making claims for benefits under the new disability provisions will be the same as that under the disability freeze provisions. That procedure is as follows:

The applicant who believes he is eligible under the disability program applies to the nearest district Social Security Office. In his initial application he lists physicians who have attended him and institutions such as hospitals where he has been a patient. He is given Form OA-D 826 which he takes to a physician of his choosing. The physician fills out the form and mails it in a self-addressed envelope to the Social Security office.

After the district Social Security office has acquired the necessary documentary evidence required, the entire file is sent to the Disability Determination Section in Columbus. There further processing takes place; the office writes for additional documentary evidence, if necessary; and in most cases either grants or denies the petition. The files are finally forwarded to the Division of Disability Operations in Baltimore, Maryland, where additional processing in a few cases may take place.

HOW THE PROGRAM WORKS

If a person has already been processed under the freeze, is 50 years old or older, and desires compensation, he should make application for payments at the district Social Security office. Mr. Wallace reported that of those who have applied under the freeze program, approximately 60 per cent of applications have been granted and roughly 40 per cent denied.

If an applicant under the freeze has been turned down, he can ask for a reconsideration of his claim. After a second denial, appeal may be made to a referee and finally to the courts.

A person who believes he is permanently dis-

abled before the age of 50 and meets certain other requirements should apply to have his earnings record frozen until such time as he is eligible to receive benefits.

Those who apply for the disability freeze before July 1, 1957, may have their benefits rights preserved as far back as October 1, 1941. For those who apply on or after July 1, 1957, the disability freeze may be granted retroactive only for one year.

Under the provisions for disabled child's benefits, benefits may continue indefinitely for a disabled person who was disabled before the age of 18 and meets certain other requirements as to eligibility.

The Disability Determination Section under the supervision of Mr. Wallace, is a branch of the Bureau of Vocational Rehabilitation, of which Marlow B. Perrin is director. The state agency administers the disability program under a contract with the U. S. Department of Health, Education and Welfare. Another key person in the set-up is Dr. Byrl M. Oser, Columbus physician, who is part-time medical consultant to the agency. Costs of the program are borne by Federal grants to the state.

The report of the examining physician is used as part of the evidence in the applicant's claim for disability. Mr. Wallace emphasized, however, that under the policy of the program the examining physician is not called as a witness to testify.

A person who qualifies for compensation under the program will in general receive the same amount of pension that he would receive if retiring at age of 65 under the OASI. The ceiling now is \$108.50 per month, the actual pension depending on earnings of the applicant. The amount received also is influenced by any pension the applicant is receiving, such as veteran's pension or Workmen's Compensation.

Here are the technical rules on how long a worker must be covered by Social Security in order to draw disability pension: He must have Social Security credit for five years of work in the 10 years before the date when his disability began and also one and one half years of work in the three years before that date.

Increased Span of Life Means Fewer Orphans

Physicians of Ohio will be interested in the statement of statisticians of a major insurance company to the effect that because people are living longer, today's children are less likely to be orphaned than was the case in past generations.

The information was developed by Metropolitan Life Insurance Company statisticians, who reported that in 1955 less than 5 per cent of children in the United States under 18 had lost one or both parents; as recently as 1920 the proportion was 16 per cent.

The report also showed children in that age group in the U. S. increased in number by more than a third during the 10 years following World War II.

They reached a record total of 55 2/3 million, a gain of more than 14 million over the 1945 figure, according to the company's statisticians.

The increase is by far the greatest in the country's history. For comparison, during the three decades of 1900 through 1930 the children at those ages increased by only 12 1/3 million.

This explanation is offered by the statisticians:

"The situation reflects essentially a new outlook toward family life by our young people—the proportion married is at an all-time high, and they are marrying and starting their families earlier."

The postwar upsurge in the number of children is concentrated very largely at ages under 10 years, a study of Bureau of the Census data shows, with the number at ages under 5 increasing by 41 per cent and at ages 5-9 by 58 per cent. In contrast, the increase at ages 10-14 was only 24 per cent, while at ages 15-17 there was actually a small decrease.

Theological students representing five divinity schools participated in the third summer training program of the Cleveland Receiving Hospital and State Institute of Psychiatry. The program included patient visitation under the supervision of staff psychiatrists, lectures and seminars.

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*Schwartz, E.: New York J. Med. 56:570, 1956.

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minimal effect on electrolyte balance — "in therapeutically effective doses . . . there is usually no sodium or fluid retention or potassium loss."* Lack of edema and undesirable weight gain permits more effective therapy particularly for those with cardiac complications.

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Health Officials Meet . . .

Cooperation Between Practicing Physicians and Health Commissioners Is Emphasized by Reports and Attendance at State-Wide Get-Together

THE OHIO STATE Medical Association and its component county societies were accorded considerable praise and recognition September 26, 27 and 28 at the 37th Annual Conference of Health Commissioners with the Ohio Department of Health.

Among conference principals lauding the Association was Dr. Ralph E. Dwork, Ohio health director, who particularly praised OSMA for its role in the state's poliomyelitis vaccination program.

Dr. Dwork said that "the State Medical Society gave its full support to our distribution program and wrote many articles in both *The Journal* and the periodic OSMAgram reminding Ohio physicians of the recommended priority groups and the inoculation schedule. I feel very certain if it had not been for the assistance of this association and the cooperation of local physicians, our program would not have been as successful as it has proven to be."

Members of the conference also heard OSMA's president, Dr. Richard L. Meiling, call on all physicians, private practitioners and health officers, to cooperate diligently in relentlessly pursuing health problems wherever they may arise.

Dr. Meiling cited the importance of stressing health and nutrition on an international level as a means of securing mutual security for the various nations.

He stressed, "In the past 10 years, every area which has caused international difficulties is an area with health problems."

President Meiling emphasized that by aiding these areas in providing political stability, economic profit, nutritive diet and health, "we will have peace in our time."

Dr. Meiling told the conference that all medical men, both private and public, should constantly strive to achieve the goal where 95 per cent of all medicine, both private and public, would be in the preventive field.

HEALTH ACTIVITIES

Dr. Dwork styled his address to the conference in the form of an annual report, in which he said about 40 per cent of Ohioans 19 years or younger and expectant mothers have had three shots of polio vaccine. He said it is the goal of the department to reach all eligible people in that age group.

Other developments during the past year cited by Dr. Dwork included:

1. A project arranged with six Ohio hospitals to study non-paralytic polio-like illness such as

encephalitis and aseptic meningitis, in an attempt to make inroads in the etiology of those syndromes.

2. Expanded virology work, a toxoplasmosis laboratory, diagnostic sera for pathogenic *E. Coli* and staphylococcal bacteriophage typing.

3. Rabies control seminars for dog wardens.

4. Significant inroads against psittacosis via a field trial of medicated bird feed at the retail level; investigation of the transmission of *leptospira pomona* from infected cattle.

5. Venereal disease seminars and accentuated case-finding activities.

6. Expansions and improvements in the fields of sanitary engineering, water pollution and air pollution.

7. Rapid development of the Ohio Cancer Registry under the guidance of the Cancer Coordinating Committee, of which five of nine appointees are from OSMA.

8. Completion of nine Hill-Burton hospital projects and approval of grants for six additional such projects.

9. Considerable increase in the number of communities fluoridating or planning to fluoridate their water supplies.

10. Expansion of activities in the Division of Industrial Hygiene, particularly in the field of toxic exposures.

At the request of Dr. Robert Markey, Wood County Health Commissioner and chairman of the Conference Committee on Maternal and Child Health and Health Education, two Ohio State Medical Association committee chairmen appeared before his section.

OUTBREAK OF INFECTIONS

Staphylococcal infections of the newborn in hospital nurseries were discussed by Dr. Thomas E. Shaffer of Columbus, chairman of the Committee on School Health of the OSMA. Dr. Shaffer related the cooperative activity in Columbus among hospitals, physicians, and the health department resulting in the identification of "Strain 42-B," the "hot strain" responsible for recent epidemics of impetigo, breast abscess and staphylococcal pneumonia in infants, and breast abscess in the mothers.

Dr. Shaffer also told of the successful methods of finding carriers, and preventing and treating the disease which were worked out in Columbus.

Following his talk the conference committee recommended to the Health Commissioner's Conference as a whole, resolutions on the subject which were later adopted by the latter body.

These resolutions urged health commissioners

to watch for presence of this disease in local newborn nurseries, work out adequate means of communication among hospitals; medical staffs and health departments regarding infections of the newborn.

Also it recommended that postpartum breast abscess and staphylococcal infections in infants under two years of age be added to the list of reportable diseases, and asked the Ohio Department of Health to make consultative services available to local departments for the purpose of dealing with future outbreaks.

MATERNAL HEALTH

Dr. A. J. Ruppertsberg, Jr., Columbus, chairman of the Committee on Maternal Health of the OSMA, discussed the Maternal Health Studies of the Ohio State Medical Association and the Columbus Academy of Medicine.

Following his talk the committee recommended that "health commissioners inform local physicians of the need for adequately stating cause of death in all maternity cases in order to assist the study of the Maternal Health Committee of the OSMA." This resolution was later adopted by the conference.

In the field of chronic diseases the conference adopted resolutions which asked the Ohio Department of Health to make an effort to "extend programs of routine admission x-rays on general hospital admissions" and to sharpen tuberculosis casefinding by improving methods of selection of populations to be surveyed.

The conference "recognized the immediate need for a facility for the recalcitrant tuberculosis patient," and requested the Ohio Department of Health to "implement the recalcitrant tuberculosis legislation recently enacted by the legislature."

Technical assistance to health districts on air pollution problems was asked and it was recommended that "the Ohio Department of Health provide more adequate supportive services to local health departments in the field of cancer control."

A resolution asking some regulation "to register, license or by some system approve or certify medical technologists in Ohio" was referred to the Ohio State Medical Association.

The conference supported efforts of the Ohio Department of Health in the stimulation and institution of a diabetes casefinding program at the local level and encouraged the State Health Department to provide administrative and laboratory assistance to local departments in this field.

In the area of communicable diseases, the conference recommended that the Ohio Department of Health purchase and furnish to local health departments suitable chemotherapeutic or antibiotic agents for use in the prevention of recurrent attacks of rheumatic fever.

It was suggested that these agents be made available to private physicians upon request di-

rected to the local health department. It was stipulated that the details of the program should be "worked out by the local health commissioner after consultation with his local medical society."

The conference supported the concept of pediatric cardiac clinics subsidized by the Ohio Department of Health as a part of their heart disease program, provided the concept of these clinics has the approval of the Ohio State Medical Association.

It was suggested that these clinics be "instituted and managed on the local level by the local health commissioner after consultation with his local medical society."

It was recommended that the Ohio Department of Health study the advisability and feasibility of the alteration of existing statutes so as to permit the licensure of dogs to be contingent upon vaccination for rabies.

Akron Area General Practitioners Schedule Program November 14

The first annual postgraduate day sponsored by the Summit County Chapter of the American Academy of General Practice will be held on Wednesday, November 14, in the auditorium of the Akron General Hospital.

Registration will begin at 8:30 a.m. with the program starting at 9:30. A \$5 registration fee will include luncheon. Category I credit of 6½ hours has been authorized for this session. Dr. Robert J. Ferris, 606 Metropolitan Building, Akron 8, is program chairman.

Physicians putting on the program are from Ohio State University College of Medicine. The program has been announced as follows:

MORNING SESSION

Office Diagnosis and Treatment of Anemia, Dr. Robert L. Wall.

Practical Application of Antibiotic Therapy, Dr. Samuel Saslaw.

Office Gynecology and Uterine Bleeding, Dr. William E. Copeland.

Panel Discussion on Jaundice, Dr. Wall, Dr. Saslaw, Dr. Copeland and Dr. Luther M. Keith.

AFTERNOON SESSION

Peripheral Vascular Disease, Dr. Keith.

Indications for Cardiac Surgery, Treatment of Coronary Disease and Management of Congestive Heart Failure, Dr. Joseph M. Ryan.

Treatment of Hypertension, Dr. James F. Schieve.

Panel Discussion on Surgery in Patients with Cardiovascular Disease, Drs. Keith, Schieve and Ryan.

The Veterans Administration is sponsoring a series of clinical conferences through January 30, 1957, at the VA's Cleveland Regional Office. Dr. Charles Berns is conference chairman.

In Our Opinion:

Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

RESIGNATION OF PORTERFIELD A REAL LOSS FOR OHIO

Resignation of Dr. John D. Porterfield as director of the Department of Mental Hygiene and Correction to become an assistant surgeon general of the United States Public Health Service means, of course, that Ohio is losing one of its all-time "bests" among those who have held administrative positions in the state government.

The medical profession of Ohio hates to see Dr. Porterfield leave. It holds him in high esteem. It learned by working with him in his recent position, and formerly when he headed the state health department, that he is an efficient, sincere and honest administrator, and a fine fellow, in addition.

Dr. Porterfield rendered a great service to the people of Ohio in the two important posts he held. The public health office in Washington is lucky to have been able to get him. It will soon find out that it has acquired a real asset.

Dr. Porterfield, both as director of health and director of mental hygiene here in Ohio, established records which should be mighty useful guides for those who will fill those positions throughout the years.

It is of more than passing interest to note that Dr. Porterfield's salary was from \$4,000 to \$10,000 less than some of the physicians on his staff and on the state hospital staffs. The same thing was true when he was associated with the health department. His salary as department head was set by statute; the other salaries by administrative authorization or by civil service rule.

It's about time for the General Assembly to take a serious look at this problem—and do something about it. Seems mighty silly to continue a system which makes it impossible for the boss to earn even as much as many of his subordinates.

HEARING REVEALS AMA FUNDS SPENT JUDICIOUSLY

Once in a while some person, (may be a physician) without knowing the facts, accuses the AMA of being "just a lobbying organization." Too bad that some folks must pop off without having the evidence in hand.

At recent hearings in Washington on lobbying, representatives of the AMA have testified. They have presented facts.

These facts show that the AMA budget is broken down as follows: Reserves, 3 per cent; supplying information to members, 9 per cent;

public information, 19 per cent; socio-economic activities, 6 per cent; publication of journals and other scientific activities, 60 per cent; Washington Office expenses, law department and legislative activities, 3 per cent. The legislative activities actually are 2.5 per cent of the budget.

If that isn't a well balanced budget, we'll eat it. Those who pay AMA dues ought to be well satisfied, realizing that their dollars are being spent in a judicious manner.

TIME TO MAKE YOUR 1956 CONTRIBUTION TO AMEF

Have you sent in your contribution to the American Medical Education Foundation? Perhaps you chose to make your gift directly to the Alumni Fund of your own medical school. That's O.K., too. The route isn't as important as the destination.

However, if you haven't struck a blow for liberty in medical education by either route, won't you dig out that letter you received recently from Dr. Merrill Prugh, Chairman of the Ohio AMEF committee, and send in your contribution in the postpaid envelope which he enclosed for that purpose?

The cause is worthy. The need is great. The address is: American Medical Education Foundation, 535 N. Dearborn St., Chicago, Ill., just in case you have misplaced that envelope. Remember that you may earmark your contribution for your own school; also that your gift is an income tax deductible item.

CONGRESS SHOULD GET OUT OF THE POLIO VACCINE PICTURE

Big hassle is going on before a Congressional Committee as to whether or not the Government paid too much for the Salk polio vaccine which it bought and distributed to the various states, without cost to the states.

If Congress had kept its fingers out of the matter and let the states secure the vaccine through regular channels as they have been getting other types of vaccine and serum, Congress would not have to be worrying itself now about polio vaccine.

Frankly, we don't believe anyone tried to fleece anyone in the sale of polio vaccine.

Congress—and politics—never should have got into the polio picture.

Some of the states—like Ohio—did a swell job of distribution—keeping the boat on an even keel under difficult circumstances.

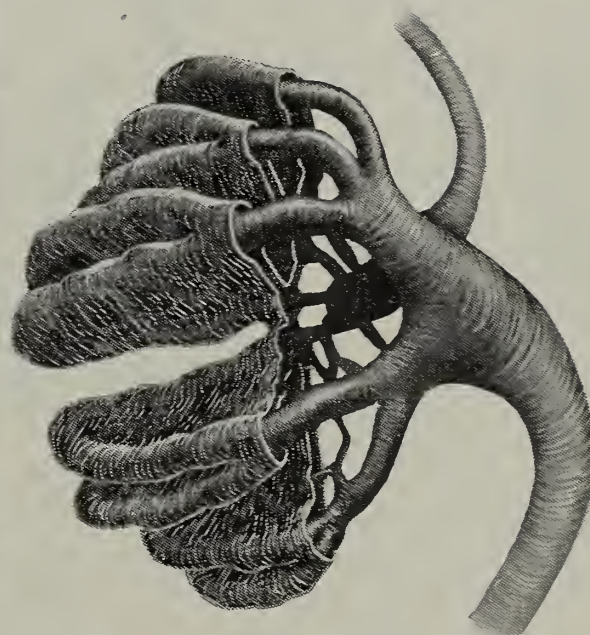
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side of other biologicals as a part of the day-by-day practice of preventive medicine and ceases to be something extraordinary, the better off everyone will be.

Of one thing we're absolutely sure: Congress should get out of the act pronto.

HOSPITAL COSTS BIGGEST SHARE OF MEDICAL DOLLAR

For the first time, Americans are spending more for hospital care than they are for physician services, according to *The Journal of the American Medical Association*.

Personal expenditures for hospital services during 1955 were 3.13 billion dollars as compared with 3.07 billion dollars for physician services. These figures, which appeared originally in the July, 1956, issue of *Survey of Current Business*, published by the U. S. Department of Commerce, "mark 1955 as a turning point in the history of medical economics."

In 1929 it was estimated that 959 million dollars was spent for physician services, while only 403 million was spent for hospital care. By 1950, expenditures totaled 2.435 billion for doctor services and 1.975 billion for hospital services.

In other words, the physician's share of the "medical care dollar" declined from 33 cents in 1929 to 27.2 cents in 1955, whereas the hospital's share rose from 14 to 27.8 cents.

One reason for the rise in hospital service expenditures is that hospital services have expanded. More persons are hospital patients and more babies are born in hospitals. Another reason is that hospital prices have risen more rapidly than physicians' fees because hospitals are more exposed to inflationary forces.

According to the Consumer Price Index, physicians' fees in 1955 were 65.8 per cent above the 1935-39 level as compared with an increase of 237.7 per cent in the index of hospital room rates and 91.4 per cent in the whole consumer price index.

THINGS TO TELL PATIENTS ABOUT OBESITY AND DIETS

Many Ohio physicians are being questioned, no doubt, by patients regarding the so-called "Rockefeller Diet" which has been receiving so much newspaper and magazine publicity.

They should be prepared to give their inquiring patients some sound advice on this—in fact, some do's and don'ts on dieting generally.

The publicity about the "Rockefeller Diet" has caused the American Medical Association's Council on Foods and Nutrition to reiterate by formal statement the warning that obesity continues to be a medical problem.

The Council stressed that as a medical problem, obesity should be handled by a physician

who will decide whether weight reduction is safe and necessary.

The physician, in such cases, will determine the manner in which such reduction should be obtained, the statement continued.

The council added, "Ethical advertisers of foods recommended for weight-reducing regimens have likewise stressed the importance of a medical consultation prior to reduction of the food intake."

Pointing out that lay articles insufficiently stressed the data accompanying the diet, the council warned that "the experimental character of such an abnormal diet makes it imperative for the physician to recommend its use only after careful investigation."

The statement concluded, "The council re-emphasizes that dieting because of obesity is a medical problem. Editors of lay journals can cooperate in this important matter; if weight reduction and related problems are discussed in their columns, they should make sure that the health of the people is preserved by urging consultation with a physician. The Council's services are available for reviewing popular articles on foods and nutrients."

In a letter to the editor appearing in the *AMA Journal's* Aug. 25 edition, Dr. Vincent P. Dole, a member of the Rockefeller Institute, stated that in any discussion of obesity treatment, the important consideration is that all reducing diets are merely symptomatic measures.

Dr. Dole, also a physician to the Rockefeller Institute Hospital, added, "A physician must regard an obese person as the victim of a chronic disease. When this fact is recognized and understood, then he can prescribe treatment—through diet and otherwise—to fit the condition."

"Any diet becomes a fad if it is claimed to solve the problem of obesity. An essential part of any diet is a wise doctor trained to manage a chronic and, at the present time, incurable disease."

Two Institutions Awarded Grants For Research Facilities

Members of the medical profession in Ohio will be interested to learn that two institutions in the state recently received grants to help them expand medical research facilities.

Christ Hospital Institute of Medical Research, Cincinnati, has been awarded \$185,000 by the National Advisory Council on Research Facilities. The grant is to be used for construction on an additional floor on the institute's medical research building.

Also in Cincinnati, the Elizabeth Gamble Deaconess Home Association, has been granted \$184,000 by the U. S. Public Health Service for construction of medical research facilities. That grant was extended with the provision that the association match it with a similar amount of capital.

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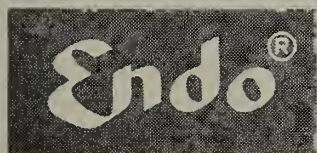
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1. Blank, P., and Boas, H.: Ann. West. Med. & Surg. 6:376, 1952.

2. Piper, C. E., and Nicklas, F. W.: Indust. Med. 23:510, 1954.

*U.S. Pat. 2,628,185

Washington Roundup . . .

News From Nation's Capital of Interest to Physicians; Reports of Developments in Medical and Health Fields; Activities of Agencies

A feature of AMA's annual convention in New York City next June is to be the first International Medical Motion Picture Exhibition, sponsored jointly by AMA, the State Department and World Medical Association. Exhibition is to include motion pictures on scientific medical subjects from many WMA member nations.

* * *

U. S. Office of Vocational Rehabilitation reports 3,300 mentally handicapped persons placed in jobs by State-Federal vocational rehabilitation centers during year ending June 30, 1956. OVH during that period granted \$3.2 million to 245 public and private rehabilitation projects, including \$400,000 for 23 projects for mentally disturbed and deficient.

* * *

Defense Department has started conferences with AMA and other interested groups to discuss how to meet future military needs for physicians and other professional personnel now met through the special doctor draft act which expires July 1, 1957. Currently, Defense believes most of its needs can be met by recent graduates of medical schools under the regular draft act and is disposed to let the special doctors draft act die.

* * *

Major source of activity in Justice Department's tort claims section continues to be malpractice suits, with 13 instituted throughout nation from January 1 to July 1. Government currently is appealing Federal court judgment of \$210,000 granted ex-servicewoman stricken with paralysis following surgery.

* * *

Surgeon General Dan C. Ogle, dedicating new hospital at Wright-Patterson Air Force Base Dayton recently, said Air Force, exclusive of military patients, in 1955 recorded more than six million outpatient visits by dependents. Hospital admissions totaled 163,000; average daily bed occupancy was 2,580. Added to those figures are some 70,000 births in Air Force Hospitals.

* * *

Consumer price index released by Labor Department September 21 showed medical care costs ranked No. 2 among all consumer items, housing and services in August; exceeded only by public transportation.

* * *

Special personnel of Public Health Service to begin sickness and injury census in March. Plans are to cover 12,000 families in house-to-house survey of illness and medical care expenditures

by June 30. Plans also are to call for medical examinations of persons selected from household canvass to compare histories those persons report via census questionnaire with actual diagnostic findings.

* * *

U. S. House Interstate and Foreign Commerce Committee staff is scheduled to start, probably in December, hearings on medical education problems as part of fact-finding survey authorized by committee. Study is aimed at two broad aspects of medical education—financial needs of medical schools, and supply and demand for medical school applicants and physicians.

* * *

Six-man Advisory Committee on Hospital Facilities and Services has been appointed by Health, Education and Welfare Secretary Folsom to study and make recommendations on (1) design and organization of hospital units more closely related to specific needs of patients as to severity of illness and disability, (2) development of units in which patients could provide more services for themselves, (3) feasibility of hospital rooms for patients admitted for part of one day, (4) ways in which hospitals can provide services to patients in their homes.

* * *

Washington Report on Medical Sciences says Internal Revenue Service continues firm stand against deductibility of medical travel expenses. The Service in a recent case ruled that expenses resulting from need for change in patient's environment for improvement of his morale, "and general mitigation of his condition, which might result from a general improvement in his health," are not deductible.

* * *

United States has given \$1.5 million to Pan American Sanitary Bureau's 1957 malaria eradication campaign. Donation is in addition to nation's 1956 contribution to PASB, amounting to \$1,386,000, or two-thirds of PASB's total budget. Program for 1957 also to expand projects in polio, diarrheal diseases, yellow fever and the zoonoses. In addition, eradication programs are to be continued against malaria, *Aedes aegypti* mosquito, smallpox and yaws.

* * *

Labor Department report on coverage of older workers under collectively bargained health and insurance plans, released October 19, showed that of 300 plans analyzed, covering some five million workers, only three plans discontinued one or more benefits at age 65 or older.

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The State Medical Board has issued licenses to practice medicine and surgery in Ohio to the following physicians through endorsement of their licenses to practice in other states, or certification by the National Board of Medical Examiners (included are intended residence and medical school of graduation):

June 15—James M. Cunningham, Dayton, Univ. of Texas; Alfred L. DeSanctis, Massillon, Johns Hopkins Univ.; Herbert U. Seabrook, Dayton, Meharry Medical College; Frank M. Sheehan, Akron, Univ. of Michigan; Clifton V. Lee, Cleveland, Howard University; Melvin E. Tramitz, Lyndhurst, Marquette University.

August 28—Edward P. Ajemian, Toledo, New York Medical College; Dezso Annau, Cuyahoga Falls, Univ. of Budapest, Hungary; George J. Baibak, Toledo, Univ. of Michigan; James P. Barrett, Cleveland, St. Louis Univ.; William H. Brunie, Worthington, College of Medical Evangelists;

Charles W. Caccamise, Jr., Springfield, Univ. of Rochester; Orel H. Cagle, Columbus, Univ. of Tennessee; John W. Coles, Jr., Columbus, Temple University; Hugh J. Davis, Zanesville, Johns Hopkins Univ.; Harry Eisenberg, Toledo, Hahnemann Medical College; William S. Elliott, Columbus, Yale University;

Roy H. Fanoni, Akron, Columbia Univ.; Robert F. Feltman, Canton, George Washington Univ.; John R. Gambill, Jr., Univ. of Louisville; Armin E. Good, Toledo, Harvard Medical College; James W. Grifone, Cleveland, Univ. of Pennsylvania; Jack R. Harper, Cleveland, Univ. of Kansas; Michael M. Jaller, Cincinnati, Univ. of Lausanne, Switzerland; Howard S. Jeck, Jr., Oxford, Cornell Univ.; Alfred L. Joseph, Columbus, Meharry Medical College;

Michael A. Kachmer, Youngstown, St. Louis University; Richard A. Katzman, Cleveland, Univ. of Chicago; Jesse B. Kellum, Cambridge, Harvard Medical School; Marcus M. Key, Cincinnati, Columbia Univ.; Robert M. Kintner, Akron, Indiana University; Alexander A. Klos, Cleveland, Univ. of Frankfurt a/Main, Germany; Dieter Koch-Weser, Cleveland, Univ. of Sao Paulo, Brazil; Norman R. Korman, Univ. of Berne, Switzerland;

George I. LeBaron, Jr., Columbus, Univ. of Rochester; Aldona T. Lyon, Cleveland, Woman's Medical College of Pennsylvania; Thomas F. Meaney, Cleveland, George Washington Univ.; Patrick P. Moraca, Cleveland, Hahnemann Medical College; E. Gates Morgan, Columbus, Meharry Medical College; Paul V. Newland, Cincinnati, Univ. of Rochester; Rudolf E. Nobel, Univ. of Leiden, Holland; Warren A. Nordin, Toledo, Stritch School of Medicine, Loyola Univ.;

Rolland F. Oakes, Cuyahoga Falls, Univ. of Louisville; Charles B. Phillips, Dayton, College of Medical Evangelists; Dale C. Rehanek, Cleve-

land, Jefferson Medical College; Joseph B. Ruffin, Cincinnati, Stritch School of Medicine, Loyola Univ.; Norbert Schalet, Dayton, Univ. of Prague, Czech.; Rolf H. Scholdager, Toledo, Columbia Univ.; John N. Schuetz, Cleveland, Univ. of Budapest, Hungary; Joseph W. Simpson, Youngstown, Jefferson Medical College; Arthur K. Smith, Gallipolis, Tufts College; Harry L. Snyder, Jr., Toledo, Univ. of Michigan; Anthony A. Spagno, Cleveland, Univ. of Buffalo;

John D. Tharp, Xenia, Indiana University; George X. Trimble, Youngstown, Univ. of Toronto; William G. Wasson, Cleveland, Univ. of Rochester; Charles R. Wilcox, Columbus, Johns Hopkins Univ.; William O. Wild, Alliance, Univ. of Maryland; Thomas R. Wilson, Lima, Temple University; Sherwin S. Zeid, Cincinnati, Univ. of Illinois.

October 2—George R. Anderson, Dayton, Yale Univ.; Doris G. Beatty, Cincinnati, Univ. of Illinois; Robert P. Bolande, Willoughby, Northwestern Univ.; Berly E. Bridges, Jr., Bellaire, Univ. of Texas; Joseph D. Broderick, Cincinnati, St. Louis Univ.;

Leon D. Carson, Akron, Northwestern Univ.; Johnson H. Chow, St. John's Univ., Shanghai, China; Robert E. Cott, Bowling Green, U. of Pittsburgh; George M. Doolittle, Portsmouth, Univ. of Buffalo; Miles A. Erickson, Columbus, Univ. of Oregon; Richard M. Ewing, Cleveland, Tulane Univ.;

Leo H. French, Jr., Dayton, St. Louis Univ.; James A. Gardner, Univ. of Glasgow, Scotland; George J. Gensemer, Bellefontaine, Jefferson Med. College; Edward P. Gillette, Jr., Toledo, Univ. of Michigan; Howard G. Greene, Cleveland, New York Univ.; Harry C. Halsted, Cincinnati, Univ. of Vermont;

Christopher P. Jeffries, Youngstown, Howard Univ.; George C. Joosten, Cincinnati, Northwestern Univ.; Jane W. Kienle, Sandusky, Albany Med. College; Lawrence F. Kienle, Sandusky, Albany Med. College; Manfred Kydan, Univ. of Koenigsberg, Germany; Harrison O'Connor, Cleveland, Harvard Med. School; Paul R. Overhulse, Toledo, Johns Hopkins Univ.; Charles W. Park, Columbus, Duke Univ.;

James H. Miller, Toledo, Jefferson Med. College; Imre Schmidt, Cleveland, Univ. of Budapest, Hungary; Benjamin Schuster, Cincinnati, Univ. of Wisconsin; John J. Standifer, Youngstown, Univ. of Oklahoma;

Roy L. Thomas, Jr., Youngstown, Meharry Medical College; Isidor D. Waitzel, Cleveland, Univ. of Basel, Switzerland; Olin K. Wiland, Greenville, Jefferson Med. College; James E. Yarbrough, Jefferson Med. College.

January 15, 1957, is the deadline for submitting entries in the American Goiter Association's Van Meter Prize Award contest for essays on clinical or research investigation of the thyroid gland.



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In Memoriam . . .

Samuel Sylvester Berger, M.D., Cleveland; Western Reserve University School of Medicine, 1904; aged 72; died September 18; member of Cuyahoga County Medical Society, Ohio State Medical Association, American Medical Association, American College of Physicians, American College of Gastroenterology and a diplomate of American Board of Internal Medicine. Dr. Berger was chief of medicine at Mt. Sinai Hospital, Cleveland, and died of a heart attack while calling on patients there. He had been identified with the hospital since 1904. Born in Hungary, he came to America in 1895 with his parents. In 1925 he, along with Dr. B. S. Kline, was awarded the AMA silver medal for a convention exhibit that year. He also held memberships in the American Heart Association, American Diabetes Association and Alpha Omega Alpha. Surviving are his wife, two daughters, a son and two grandchildren.

Edward R. Garvin, M.D., Toledo; St. Louis University School of Medicine, 1931; aged 51; died September 19; member of the Lucas County Medical Society and the Ohio State Medical Association through 1955; member of American Medical Association through 1953; fellow of American College of Surgeons and American College of Obstetrics and Gynecology. A commander in the U. S. Naval Reserve, he received a Navy Commendation Ribbon and citation for meritorious service with the Marine Corps during World War II. A member of the Maumee River Yacht Club and Knights of Columbus, he also was the fifth generation of his family to hold membership in Toledo Immaculate Conception Church. Surviving are his wife, two sons and his stepmother.

Solomon M. Hartzell, M.D., Beverly Hills, Calif., formerly of Youngstown; University of Pennsylvania School of Medicine, 1909; aged 77; died September 10; member of Mahoning County Medical Society until 1944; member of American Academy of Ophthalmology and Oto-Laryngology, member of International College of Surgeons, American College of Surgeons, and Ohio State Medical Association. Surviving are his wife, a daughter and two granddaughters.

Arthur M. Hauer, M.D., Columbus; Ohio Medical University, 1906; aged 75; died September 14; member of Franklin County Medical Society and Ohio State Medical Association through 1954;

member, American Academy of Ophthalmology and Oto-Laryngology and member of American College of Surgeons; diplomate, American Board of Otolaryngology. Dr. Hauer had been semi-retired since suffering a heart attack in 1951. He is survived by a brother.

Frank Blair Kaylor, M.D., Bellefontaine; University of Cincinnati College of Medicine, 1901; aged 88; died September 29; member of Logan County Medical Society and Ohio State Medical Association; member of Bellefontaine Masonic bodies, Dayton Consistory of Scottish Rite and Antioch Temple of the Shrine; member of American Legion. Surviving are a son, Frederick W. Kaylor, M.D., Bellefontaine, and a sister.

Courtland B. Meuser, M.D., Ashland; Ohio State University College of Medicine, 1912; aged 70; died September 11; member of Ashland County Medical Society through 1950 and Ohio State Medical Association. Dr. Meuser activated the Ashland County-City Health Department and headed it until his death. He also was known throughout Ohio for Civil Defense work. He is survived by his widow.

Oscar Pan, M.D., Cleveland; University of Prague, 1902; aged 79; died September 5; member of Cleveland Academy of Medicine, Ohio State Medical Association and American Medical Association. Surviving are his widow, a son, a daughter and a brother. He migrated to Cleveland in 1907.

Harry E. Patrick, M.D., Youngstown; University of Michigan Medical School, 1909; aged 72; died September 28; member of Mahoning County Medical Society, Ohio State Medical Association, American Medical Association and American College of Physicians. For 16 years he was a prominent member of the Youngstown Board of Education. He is survived by four sons and three daughters.

Thomas A. Quinn, M.D., Napoleon; Toledo Medical College, 1909; aged 70; died September 2; member of Henry County Medical Society and Ohio State Medical Association; was American Medical Association member through 1953. He served several terms as Henry County coroner, was a member of the American Legion, Knights of Columbus, Elks; he served in the Army Medical Corps during World War I. Surviving are

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his widow and a son, Dr. Thomas W. Quinn, a diplomate of the American Board of Internal Medicine and on the Marshall Field Clinic staff, Chicago.

William A. Teveluwe, M.D., Blanco, Texas, formerly of Cincinnati; Cincinnati College of Medicine and Surgery, 1899; aged 79; died September 17; member of Hamilton County Medical Society and Ohio State Medical Association through 1949. Formerly president of St. Mary Hospital, Cincinnati, he moved to Texas in 1948 after suffering a heart attack. He was a member of Northside Council, Knights of Columbus, Queen City Post, American Legion, all of Cincinnati; a member of the American Congress of Physical Medicine and Rehabilitation, and past vice-president of the Hayes-Blanco (Texas) Medical Society. He is survived by his widow, three daughters and eight grandchildren.

Carrol H. Verovitz, M.D., Cleveland; University of Wooster Medical Department, Cleveland, 1913; aged 65; died September 10; member of Cuyahoga County Medical Society, Ohio State Medical Association and American Medical Association. He taught surgery at Western Reserve for 25 years, was a member of the scientific council of the Cleveland Area Heart Association, Cleveland Diabetes Association and in World War I served in the Army Medical Corps. He also was a member of Newburgh Masonic Lodge and Woodward Council. Surviving are his wife, a son, Dr. David Verne; a daughter and four grandchildren.

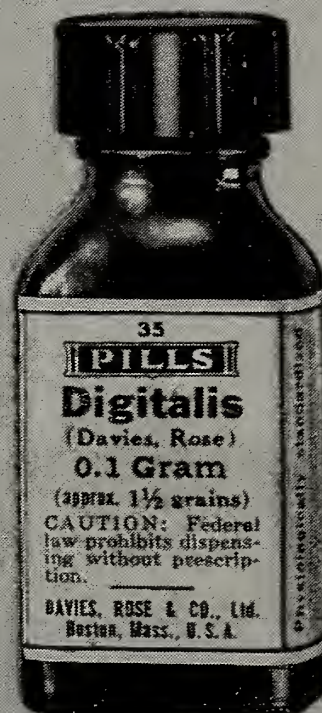
Arthur J. Willey, M.D., Marion, Ohio Medical University, Columbus, 1898; aged 86; died September 1; member of Marion County Medical Society, Ohio State Medical Association and American Medical Association through 1952. He was a member of the American College of Surgeons and the first Marion County physician to specialize in surgery. While in practice in Delaware, he founded the Jane Case Hospital there. He held an OSMA 50-year pin; was a member of Masonic orders and the Marion First Presbyterian Church. Surviving are his wife and three sons.

Homer M. Yoder, M.D., Smithville; University of Wooster Medical Department, Cleveland, 1906; aged 83; died September 30; member of Wayne County Medical Society, Ohio State Medical Association and American Medical Association. His wife, Dr. Anna Yoder, died in January, 1956. He was a member of the Wayne County Board of Health, Smithville Methodist Church and Cedar Lodge, F. and A. M. Surviving are a sister and a brother.

"The March of Medicine" television show will pioneer again when it presents the first nationwide program in color on a medical subject—Tuesday, November 27, at 9:30 p.m. The program will feature the experiences of Dr. John E. Ross, a medical missionary in the Belgian Congo.

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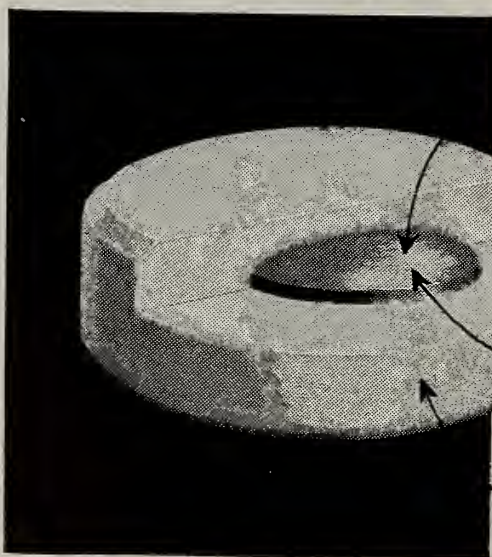
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Activities of County Societies . . .

First District

(COUNCILOR: FRANK H. MAYFIELD, M. D.,
CINCINNATI)

ADAMS

Two speakers were heard by members of the Adams County Medical Society at their October meeting. Richard L. Woodyard, M. D., presented a paper on "Emergency Room Problems" and OSMA First District Councilor Frank H. Mayfield, M. D., spoke on activities of organized medicine.

The meeting was held in the Adams County Hospital.

HAMILTON

Dr. Kenneth B. Babcock, Chicago, director, Joint Commission on Accreditation of Hospitals, addressed the Cincinnati Academy of Medicine October 2 on the topic: "Accreditation of Hospitals."

On October 16, the Academy conducted a joint meeting with the Cancer Council and heard Dr. John R. McDonald speak on "Preclinical Carcinoma." Dr. McDonald is head of the Mayo Clinic's Section of Surgical Pathology and pathology professor at the Mayo Foundation Graduate School, University of Minnesota.

Second District

(COUNCILOR: G. A. WOODHOUSE, M. D.,
PLEASANT HILL)

CLARK

A discussion of "The Management of Acute Renal Failure" and the role of the artificial kidney in such practice comprised the scientific portion of a meeting of the Clark County Medical Society opening the 1956-57 season Sept. 17. The speaker was Dr. James Schieve, assistant professor of medicine at the Ohio State University College of Medicine.

Dr. Edwin E. Ash reported attending the AMA's public relations institute in Chicago as a representative of the society.

Dr. Paul W. Schanher as chairman of the public health committee of the Community Welfare Council led planning and negotiations which in late summer resulted in organization of a community blood bank. The Springfield Junior Chamber of Commerce has accepted the task of "selling" the program to the public. Two plans of coverage will be provided—one for groups and one for individuals—with slightly varying benefits. The blood bank will be included in the budget of the United Appeals Fund.

Dr. Gail Busch, Dr. Ralph White and Dr. David Hunter have been accepted into active member-

ship and Dr. Ernest Anderson, Jr., has been accepted into associate membership.

The "Tell Me, Doctor" series of radio programs is being broadcast over a local station with support of the Pharmaceutical Society.

DARKE

Dr. Don Sando, of Dayton, spoke on "Hepatic Failure" before members of the Darke County Medical Society at their monthly meeting, held October 16 at White Shrine Temple, south of Greenville.

GREENE

Cooperation between the medical and legal professionals was the subject of an address by Edward F. Willenborg, executive secretary of the Cincinnati Academy of Medicine, at the September meeting of the Greene County Medical Society. Mr. Willenborg is an attorney himself. Other professional fields were invited to hear the speaker.

MIAMI

Dr. Geo. J. Hamwi, head of the Department of Endocrinology, Ohio State University Col-

"Patients without primary renal disease, but with albuminuria and high nonprotein nitrogen due to congestive circulatory changes, can be adequately and safely treated with Neohydrin for long periods of time."*

*Griffith, G. C.; Dimitroff, S. P., and Thorner, M. C.: *Ann. Int. Med.* 45:7, 1956.

07656

lege of Medicine, addressed members of the Miami County Medical Society on "Present Status of Hormone Therapy" at the society's monthly meeting October 12 at Dettmer Hospital, Troy.

Members of the Society were asked to help disabled persons to vote in the November election, as well as to take time to vote themselves.

MONTGOMERY

Featured speaker at the third annual cancer symposium October 3 sponsored by the Montgomery County Medical Society and Montgomery County Society for Cancer Control was Dr. Arthur M. Sutherland of the New York City Memorial Center and associate clinical professor of medicine at Cornell University Medical School.

Third District

(COUNCILOR: JAMES R. JARVIS, M. D., VAN WERT)

ALLEN

Guest speaker for the September meeting of the Allen County Medical Society was Dr. B. S. Kline, pathologist at Mt. Sinai Hospital Cleveland. His topic was "Present Status of Serodiagnosis of Syphilis" and "Tissue Changes in Allergy." Members met at Shawnee Country Club.

Fourth District

(COUNCILOR: PAUL F. ORR, M. D., PERRYSBURG)

LUCAS

The Lucas County Medical Society and Toledo Academy of Medicine has concluded a series of four panel discussions on health problems conducted for the public. Subjects for discussion were nerves, heart, intestines and new medical advancements.

The meetings, held in the Doermann Theater, Toledo University, were co-sponsored by the Medical Advancement Trusts of Maumee Valley Hospital, the University of Toledo Medical Institute and WSPD.

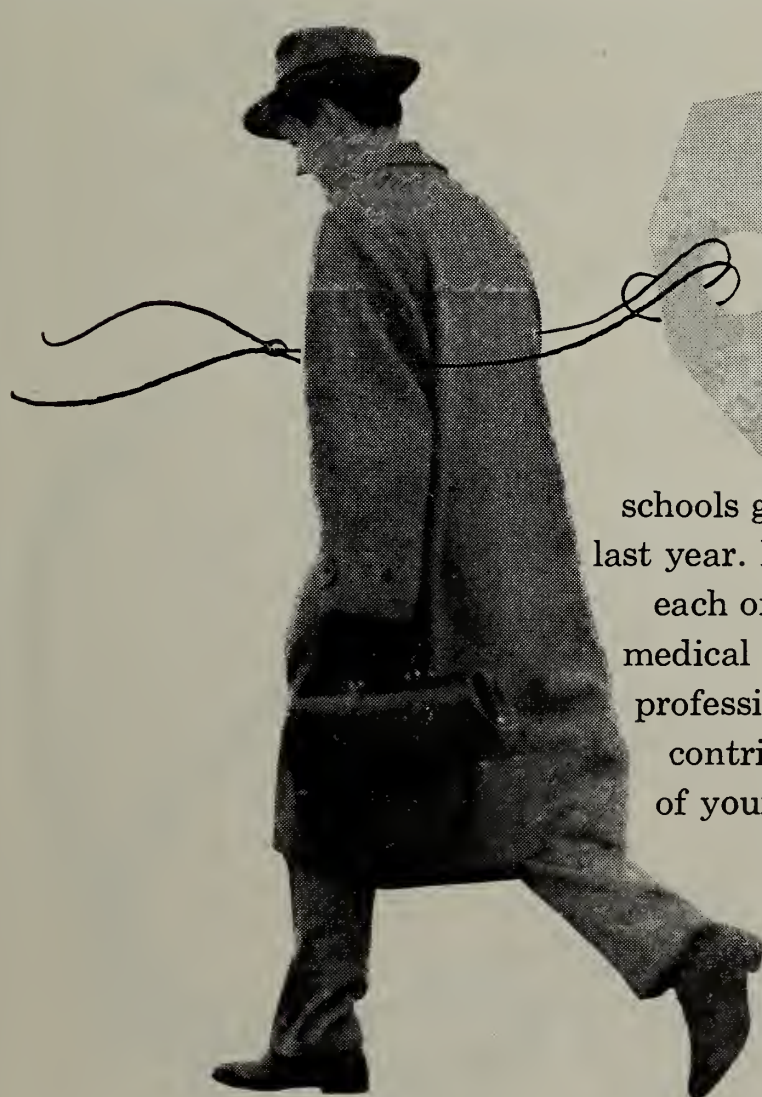
PAULDING

Dr. K. C. Evans has been presented a 50-year Ohio State Medical Association pin and certificate through the Paulding County Medical Society. Presentation was made at the September meeting by Dr. T. P. Fast, society president, and Dr. K. A. Pritchard, society vice-president.

SANDUSKY

The Sandusky County Medical Society met on October 17 for dinner and a program at Serwin's Restaurant, Fremont. Speaker for the occasion was Dr. J. S. Hart, of Sandusky, who spoke on "Anesthetic Problems in General Practice."

On November 14, a trip to the Eli Lilly and



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America's medical schools graduated 6,845 new doctors of medicine last year. It costs more than \$13,356 to train each of them. Most of this becomes medical school operating deficit which we as a profession must help meet. We will send your contribution along to the medical school of your choice if you prefer.



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Company Indiana plant will take the place of the monthly meeting.

Dr. C. D. Miller has been appointed chairman of a committee to plan the annual Christmas party on December 12.

WOOD

Civil Defense was the subject of discussion at the September meeting of the Wood County Medical Society, held at Bowling Green.

Fifth District

(COUNCILOR: GEORGE W. PETZNICK, M. D.,
CLEVELAND)

CUYAHOGA

October scientific meeting of the Cleveland Academy of Medicine was combined with the scientific assembly of the Interstate Postgraduate Medical Association. The Association's Scientific Assembly was in session in Public Hall October 22 through 25.

Section meetings of the Cleveland Academy of Medicine during October included one on "Surgical Infections," by the Section on Surgery of Trauma, and one by the Experimental Medicine Section concerning "Ammonia Uptake by the Extremities and Brain in Hepatic Coma," "Electrolyte Excretion Following Trauma," "Desoxyribonucleic Acid Content of Human Spermatozoa; Infertility Studies," and "A Method for Studying Hepatic Blood Flow Using Radio-Iodination Techniques."

Sixth District

(COUNCILOR: CARL A. GUSTAFSON, M. D.,
YOUNGSTOWN)

MAHONING

Dr. Preston C. Iverson, associate professor in plastic surgery, Graduate School of Medicine, University of Pennsylvania, addressed the September meeting of the Mahoning County Medical Society, his topic being "The Use of Abrasive Techniques in Medical Practice."

Approximately 100 members of the Medical Society, Medical Dental Bureau and Corydon-Palmer Dental Society attended the annual golf meet held at the Youngstown Country Club August 23.

PORTAGE

Arthritis is being licked, Dr. Russell L. Cecil, medical director of the National Arthritis and Rheumatism Foundation, told the members of the Portage County Medical Society at their September meeting, held at Twin Lakes Country Club.

Speaking on "Advances in Arthritis," Dr. Cecil said the disease "has been terribly neglected." He said that while the foundation is

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young, "it has had a healthy, but not spectacular growth."

At noon on September 26 at Twin Lakes Country Club, the Portage County Medical Society held a luncheon which 75 per cent of the members attended. The Society was honored to have Dr. Russell Cecil, New York City, speak to them on the subject of "Recent Advances in the Treatment of Rheumatic Diseases."—Arthur L. Knight, M. D., Secretary-Treasurer.

SUMMIT

Speaking on "Nutrition and Atherosclerosis," Dr. Frederick J. Stare, professor of nutrition, Harvard University School of Public Health, addressed members of the Summit County Medical Society at their October meeting.

Dr. Stare described the important part diet and nutrition play in both experimental and clinical studies of atherosclerosis, and current developments in that field. A dinner honoring Dr. Stare preceded the scientific meeting.

"Health and Cancer Detection" was the subject of the first of a series of three medical forums held under sponsorship of the Summit County Medical Society in October. The second forum, held November 9, was on "Your Health and Blood Pressures" while the final forum, scheduled November 23, is on "Your Health and Emotions."

TRUMBULL

Dr. Henry Falk, chief of gynecology at Beth Israel Hospital, New York City, spoke on "Office Treatment of Lesions of the Cervix" at the September meeting of the Trumbull County Medical Society and Auxiliary, held at the Trumbull Country Club.

Eighth District

(COUNCILOR: WILLIAM D. MONGER, M. D., LANCASTER)

MUSKINGUM

Dr. Paul C. Williams, clinical professor of orthopedic surgery and authority on the "low back," spoke on that subject before members of the Muskingum County Medical Society at their October meeting.

Dr. Williams is a native of Belmont County, Ohio.

Ninth District

(COUNCILOR: C. L. PITCHER, M. D., PORTSMOUTH)

JACKSON

A sound film on the heart was shown at the September session of the Jackson County Medical Society, following a dinner and business meeting.

SCIOTO

"Psychiatry in General Practice" was the topic discussed by Dr. George T. Harding of Harding

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GYNECOLOGY & OBSTETRICS—Office & Operative Gynecology, two weeks, Feb. 11. Vaginal Approach to Pelvic Surgery, one week, February 4. General & Surgical Obstetrics, two weeks, Feb. 25.

MEDICINE—Electrocardiography & Heart Disease, two-week basic course, Mar. 11. Gastroenterology, two weeks, May 13. Dermatology, two weeks, May 6. Gastroscopy, two weeks, Mar. 18.

RADIOLOGY—Diagnostic X-Ray, two weeks, Nov. 26. Clinical Uses of Radioisotopes, two weeks, May 6.

UROLOGY—Two-week course, Apr. 1. Cystoscopy, ten days, by appointment.

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Sanitarium, Worthington, at the October meeting of the Scioto County Medical Society.

Members also viewed a film on cancer of the head and neck.

Tenth District

(COUNCILOR: E. H. ARTMAN, M. D., CHILLICOTHE)

FRANKLIN

"Peripheral Vascular Disease" with emphasis on the larger arteries was the topic discussed before the October meeting of the Columbus Academy of Medicine by Walter F. Kvale, M. D., consultant in medicine at the Mayo Clinic, Rochester, Minn., and associate professor of medicine at the Mayo Foundation, University of Minnesota Graduate School.

Eleventh District

(COUNCILOR: H. T. PEASE, M. D., WADSWORTH)

RICHLAND

The September meeting of the Richland County Medical Society brought action putting the society on record as recommending polio immunization to all age groups.

The recommendation followed a review of 18 polio cases in the area, 10 of which involved individuals 18 years or older and eight of those 10 being in the 20-30 age group.

Members attending the meeting also heard Dr. James P. Hughes, assistant professor of occupational medicine at The Ohio State University College of Medicine, speak on industrial medicine.

WAYNE

Members of the Wayne County Medical Society are cooperating with the Orrville chapter of the American Association of University Women in presenting a fall series of medical education discussion groups.

Society members included as lecturers in the adult education series are Drs. John Paul Miller, Robert E. Reiheld, George Iten, Robert Baer, Edwin J. Feltes, Lloyd Dowell, Max Haase, Raymond J. Py, Jr., and William Beam.

At their September meeting, held in Dunlap Memorial Hospital, members heard Dr. J. W. Ewing of Akron speak on "Plastic Surgery." A business session followed his address.

Phi Delta Epsilon Sponsors Program in Cleveland

Phi Delta Epsilon, medical fraternity, will sponsor its 10th annual lectureship on Friday, November 9, at 8:00 p. m. It will be held in the Allen Memorial Medical Auditorium, 11000 Euclid Ave., Cleveland. The speaker will be Dr. Paul A. Bunn, associate professor of medicine, Upstate Medical Center, Syracuse, N. Y., who will discuss "The Usefulness of the Various Antimicrobial Agents in the Management of Human Infections."

for November, 1956

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3—Mrs. C. A. Colombi, Cleveland

Recording Secretary—Mrs. Lester W. Sontag, Livermore St.,
Yellow Springs

Corresponding Secretary—Mrs. Earl Young, 170 Brookline
Ave., Youngstown

Past-President and Finance Chairman—Mrs. Karl Ritter,
1420 Shawnee Rd., Lima

Chairman Publicity Committee—Mrs. Carl F. Goll

ALLEN

The initial meeting of the Auxiliary to the Lima and Allen County Academy of Medicine honored new members and wives of interns and resident physicians. For this meeting, there was a tea in the home of Mrs. C. H. Leach on September 25. Assisting Mrs. Leach were Mrs. R. E. Bushong, Mrs. F. A. Hemsath and Mrs. W. B. Light. Mrs. V. H. Hay provided instrumental music.

Seven projects will keep members of this Auxiliary busy during this coming season. The projects are as follows: (1) Sponsoring a Scholarship Ball, proceeds of which go to the Auxiliary's loan fund for student nurses; (2) A nurse recruitment tea for Allen County high school students; (3) Cooperating with the YWCA in sponsoring the Best Year's Club; (4) Cooperating in mental health programs and with the Northwest Guidance Center; (5) Supplying local hospitals with washable slippers for patients use; (6) Continuing to help the Lima Public Library in Distribution of books at St. Rita's Hospital; (7) Cooperating with the state and national auxiliaries in any special projects.

Officers are Mrs. R. P. Epstein, president; Mrs. H. C. Kingsbery, President-elect; Mrs. C. L. Blumstein, vice-president; Mrs. O. A. Horak, secretary; and Mrs. R. G. Hendershot, treasurer.

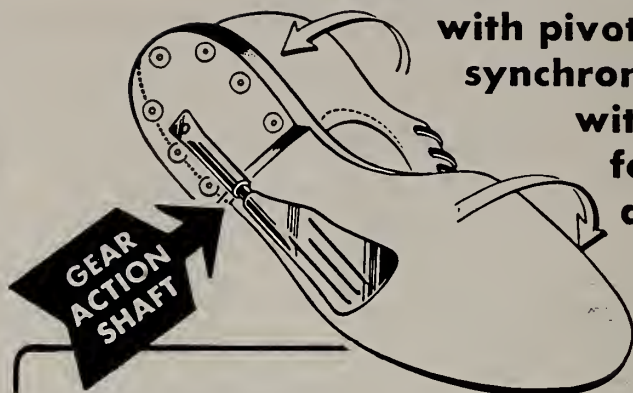
ASHTABULA

The Ashtabula Medical Auxiliary held a dinner meeting at the Hotel Ashtabula on September 11. Plans were made for the annual Scholarship Dance this year to be held on December 8. The Auxiliary took on an additional project, that of helping the handicapped children of Ashtabula County.

CLARK

A tea honoring new members of the Woman's Auxiliary to the Clark County Medical Society was held on September 20 in the home of Mrs. George Parker. New to the organization are Mrs. Gail Busch, Jr., of New Carlislye, and Mrs.

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Officers for the year are Mrs. Cook, president; Mrs. Robert A. McLemore, president-elect; Mrs. Max D. Graves, vice-president; Mrs. Harley, recording secretary; Mrs. W. P. Montanus, corresponding secretary; and Mrs. Max Gerke, treasurer.

Three students were graduated this year from nurses' training with the assistance of the Woman's Auxiliary scholarship. Six other students are in training on the scholarship program.

CLINTON

Dr. Robert Conard, health commissioner of Clinton County, was guest speaker for the Woman's Auxiliary to the Clinton County Medical Society when 11 members met on September 5 at the General Denver Hotel. Dr. Conard gave an interesting resumé of the extensive duties of the health department in all of the schools of the county.

Mrs. Robert M. Cronebaugh and Mrs. Roy D. Goodwin were hostesses for this first meeting of the new year, and Mrs. Nathan S. Hale, president, conducted the business session. New programs were distributed and discussion was held concerning the full calendar of events which has been planned for the year.

COLUMBIANA

Plans to work on the project outlined for all state auxiliaries under the American Medical Education Fund were discussed at the opening fall luncheon of the Woman's Auxiliary to the Columbiana County Medical Society on September 25 in the Wick Hotel, Lisbon.

The group will stage fund-raising events for money to be used in the support of medical schools by the American Medical Education Fund.

Business was conducted by Mrs. Wm. J. Horger, of East Liverpool, president. The meeting opened with a moment of silent prayer in memory of Mrs. V. E. McEldowney, a member who died recently.

A program on *Today's Health* was presented by Mrs. A. P. Falkenstein of Salem.

COSHOCTON

The Woman's Auxiliary to the Coshocton County Medical Society met with Mrs. Floyd W. Craig, Coshocton, on September 11. Mrs. A. H. Magness, a new member, was welcomed into the Auxiliary.

A film, entitled "Then There Were Four," was shown by Thad Slaughter of Coshocton High School, the theme being "Safety."

ERIE

A nautical party launched the new season for the Woman's Auxiliary to the Erie County Medical Society on September 10. The Sandusky Yacht Club was the appropriate spot chosen by the committee trio: Mrs. John Grant, Mrs. E. J.

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Martos and Mrs. Harold Bolman. Mrs. W. C. Seiler presided over the business session. Reports on book cart service maintained by Auxiliary volunteers were important on the agenda. Another important matter under discussion was the plan for election time activity whereby members will visit the home of invalids and shut-ins to obtain notarized ballots.

Serving with Mrs. Seiler as officers this year are Mrs. W. P. Skirball, president-elect; Mrs. P. S. Lafollette, vice-president; Mrs. C. R. Swanbeck, secretary; and Mrs. H. F. Kesinger, treasurer.

FAIRFIELD

The Woman's Auxiliary to the Fairfield County Medical Society entertained with a luncheon on September 7 for the pleasure of the graduating nurses of Lancaster-Fairfield Hospital. Favors presented each new nurse were miniature heart-shaped china picture frames containing the nurses' own graduation picture.

FRANKLIN

Franklin County's work in the field of cancer education and detection highlighted the first fall meeting of the Woman's Auxiliary to the Columbus Academy of Medicine on September 17.

A program aimed at driving home a message was arranged by Mrs. William Clatworthy, Jr. The luncheon meeting had three men, prominent in the field of cancer in Columbus, sharing the program. Dr. Charles Doan, dean of the College of Medicine, Ohio State University; Rev. Dr. Robert W. Fay, rector, Trinity Episcopal Church, and president of the Franklin County Unit of the American Cancer Society; and Paul Walker, executive secretary of the Franklin County Unit.

A Columbus-produced and inspired film, "Five Times Three," was shown during the program. The film showed the outstanding attributes of the over-all cancer program.

Mrs. George I. Nelson is the newly-elected president to the Auxiliary.

GREENE

Seventeen members and nine guests were present at the luncheon of the Woman's Auxiliary to the Greene County Medical Association held at Highview Terrace, Bellbrook, September 28. Mrs. William Evans, Youngstown, State President, gave the main talk.

Greetings were extended by Mrs. Frank Staton, Dayton, District Counselor. Guests were present from Wilmington and Lebanon.

LORAIN

Mrs. Joseph L. Bilton, president of the Woman's Auxiliary to the Academy of Medicine of Cleveland, was the guest speaker following the luncheon meeting of the Woman's Auxiliary to the Lorain County Medical Society on September 20 at the Sheffield Restaurant.

An informal discussion of problems of at-

tendance, programs and service, common to many auxiliaries was presented by Mrs. Bilton.

LAWRENCE

Members of the Lawrence County Medical Auxiliary honored three young ladies of the nursing profession on August 26 with a tea at the home of Dr. and Mrs. Ralph Massie.

For the first time the Auxiliary instituted a scholarship plan to be awarded annually to young ladies either in nurses's training or entering training. Under the new plan, the Auxiliary will award \$100 for the scholarship each year.

Mrs. Barney Osborne is the new president of the Auxiliary.

MAHONING

The Woman's Auxiliary to the Mahoning County Medical Society opened its season with a luncheon at Tippecanoe Country Club on September 26. The Sixth District meeting was announced to be held on October 24 at the Jade Room of the VFW with newscaster Warren Guthrie as featured speaker and all state officers as guests.

MARION

Mrs. Francis Kubbs was elected the new president of the Woman's Auxiliary to the Marion County Medical Society at its meeting on September 10. Mrs. David J. Hickson is the new secretary.

MONTGOMERY

In conjunction with the Montgomery County Medical Society, this Auxiliary co-sponsored a medical exhibit at the Montgomery County Fair, September 1 through 5. All of the members volunteered their time in "manning" the exhibit booth. The exhibit, "Home Accidents" was obtained from the exhibit division of the AMA.

RICHLAND

Forty-six members of the Woman's Auxiliary to the Richland County Medical Society attended the first fall luncheon of that group on September 10 at the Women's Club. Mrs. F. M. Wadsworth, the new president, conducted the business session. She is being assisted this year by the following executive board: Mrs. Paul Lee, president-elect; Mrs. Harry Wain, vice-president; Mrs. Charles Butner, treasurer; Mrs. Carl M. Quick, recording secretary; and Mrs. Sigmund Smedal, corresponding secretary.

TUSCARAWAS

Five new members and one associate member of the Woman's Auxiliary to the Tuscarawas County Medical Society were honored at a tea given September 20 in the home of Mrs. H. F. Van Epps in Dover. The new members are Mrs. Arthur Stevenson and Mrs. C. M. Fisher of New Philadelphia, Mrs. D. K. Lindberg of Uhrichsville, Mrs. Ray Klinger of Baltic, and Mrs. James Martin of Dover.

Mrs. Benjamin Piloff, the new president, con-

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ducted the business session. This Auxiliary has attained 100 per cent membership, a distinction reported by no other Auxiliary in the State of Ohio.

Another loan was made to a girl in her second year of nurses' training, and a Future Nurses' Club in the Dennison High School is being organized.

Resolutions of respect in memory of the late Mrs. W. W. H. Curtiss of Dennison were read and contributions in her memory have been made to the Memory Fund of Twin City Hospital in Dennison and to the American Medical Education Fund.

Assisting Mrs. Van Epps were members of the executive committee.

New Members of OSMA

The following are the names of the new members of The Ohio State Medical Association since September 1, 1956. The list shows the county in which they are affiliated, city in which they are practicing, or temporary address in cases where physicians are taking postgraduate work.

HAMILTON COUNTY
Domenico J. Foglia,
Cincinnati

Francis J. Waickman,
Cuyahoga Falls

SUMMIT COUNTY
Veronika Adams, Akron
Eugene V. Reilly,
Cuyahoga Falls

WASHINGTON COUNTY
Donald E. Fleming,
Vincent

Obstetrics and Gynecology Board

The scheduled examination (Part I) for candidates of the American Board of Obstetrics and Gynecology will be held in various cities on February 1, 1957. Details may be obtained from Dr. Robert L. Faulkner, Secretary of the Board, 2105 Adelbert Rd., Cleveland 6, Ohio.

COMING MEETINGS

Ohio State Medical Association, Annual Meeting, Columbus, May 14-16, 1957.

American Medical Association, Clinical Session, Seattle, Wash., November 27-30.

Bunts Education Institute, Course in Blood Bank Management, Cleveland Clinic, Cleveland, November 15-16.

Cleveland Chrysanthemum Ball, Sponsored by the Woman's Auxiliary to the Academy of Medicine of Cleveland, Statler Hotel, November 17.

Ohio Academy of General Practice, Seminar on Hypnosis, Deshler-Hilton Hotel, Columbus, November 30 - December 2.

Summit County Chapter, American Academy of General Practice, Postgraduate Day, Akron General Hospital, November 14.

Western Surgical Association, Netherland Plaza Hotel, Cincinnati, November 29-December 1.

INDEX TO ADVERTISERS

Abbott Laboratories	1140-1141
American Meat Institute	1138
American Medical Education Foundation	1227
Ann Arbor School	1233
Appalachian Hall	1164
Ayerst Laboratories, Inc.	1228
Baker Laboratories, Inc.	1142
Bayer Company, The, Div. of Sterling Drug Co., Inc.	1168
Burroughs Wellcome & Co. (U. S. A.) Inc.	1145, 1234, 1235
Chicago Medical Society	1229
Ciba Pharmaceutical Products, Inc.	1243
Cincinnati Sanitarium	1144
Columbus Pharmacal Company	1221
Cook County Graduate School of Medicine	1230
Corn Products Sales Co. (Karo)	1150
Davies, Rose & Co., Ltd.	1223
Endo Products, Inc.	1217
Flint, Eaton & Company	1167
Foot-so-Port Shoe Company	1232
Geigy Pharmaceuticals, Inc.	1139
General Foods Corporation (Sanka)	1148
Harding Sanitarium	1162
Hoffmann-LaRoche, Inc.	Insert between pages 1196-1197
Knox, Chas. B., Gelatine Co., Inc.	1251
Lakeside Laboratories, Inc.	1133, 1226, 1233
Lederle Laboratories	1151, 1163, 1202-1203
Lilly, Eli, and Company	1172
Lloyd Brothers, Inc.	1246-1247
Loma Linda Food Company	1166
Luzier's, Inc.	1238
Magnetic Springs Foundation	1164
Mallard, Inc.	1231
McMillen Sanitarium	1162
Medical Protective Company	1230
Merck Sharp & Dohme	1137, 1146-1147, 1165, 1224-1225, 1244-1245
Neil Training School	1222
New York Polyclinic Medical School	1250
Parke, Davis & Company	1252 and Inside Back Cover
Pfizer, Chas. & Co., Inc.	1156-1157, 1211, 1239, 1240-1241, 1242
Pogue, Mary, School, Inc.	1238
Robins, A. H., Co., Inc.	Insert Between Pages 1212-1213
Rocky Glen Sanatorium	1210
Sawyer Sanatorium	1161
Schering Corporation	1158-1159, 1170-1171
Scroggins, Clayton L., Associates (Medical-Dental Management)	1219
Searle, G. D. & Company	1215
Smith, Kline & French Laboratories	1149, 1248, and Back Cover
Squibb, E. R. & Sons, Division of Olin- Mathieson Chemical Corporation	1249
Stoneman Press	1243
Tutag, S. J. & Company	1250
Upjohn Company	1143
Wallace Laboratories	1169
Wendt-Bristol Company	1232
Wickhaven Sanitarium	1237
Windsor Hospital, Inc.	1238
Winthrop Laboratories	1160, 1219
Wyeth, Inc.	1135, 1153, 1229
Year Book Publishers	1155

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Physicians seeking locations in Ohio are invited to contact the Physicians' Placement Service in the executive offices of the Ohio State Medical Association, 79 E. State St., Columbus 15. Through this medium efforts are made to establish communications between physicians seeking locations and communities where physicians are needed, or other physicians who are in need of associates.

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Northwestern Ohio Medical Association Report of 1956 Annual Meeting

An attendance of between 160 and 170 persons were present for the 112th scientific assembly of the Northwestern Ohio Medical Association in Bowling Green, October 17.

The following officers were elected: Dr. Floyd A. McCammon, Van Wert, president; Dr. Thomas D. Efstation, Tiffin, vice-president; Dr. Frank M. Wiseley, Findlay, secretary; Dr. D. J. Slosser, Defiance, treasurer.

An excellent scientific program was held, with a special talk on the role of the community hospital in disaster planning by Anthony W. Eckert, of Perth Amboy, N. J.

During the business session, brief remarks on organizational matters were made by Dr. James R. Jarvis, Van Wert, Councilor of the Third District; Dr. Paul F. Orr, Perrysburg, Councilor of the Fourth District, and Mr. Charles S. Nelson, Columbus, Executive Secretary of the Ohio State Medical Association.

The group voted to hold the 1957 meeting in Defiance on a date to be determined later.

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FOR SALE: Portable Westinghouse 3KVA X-Ray; cassettes, Bucky diaphragm, illuminator, dark room light and timer; frames, fluoroscope, developing tank, examining table, office equipment, etc. M. H. Wenzinger, Exec., New Bavaria, Ohio.

FOR SALE: Office equipment of recently deceased physician; microscope, diathermy, examining table, medical books and other items. Mrs. Mary E. Quinn, 504 Welsted St., Napoleon, Ohio; Phone 3591.

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FOR SALE: Fisher X-Ray & Fluoroscope, 88,000 volts, 60 ma., built-in Bucky; 12 yrs. old; A-1 condition; \$500. Also Fisher Diathermy, good condition, \$100. F. R. Ford, M. D., Gallipolis State Institute, Gallipolis, Ohio.

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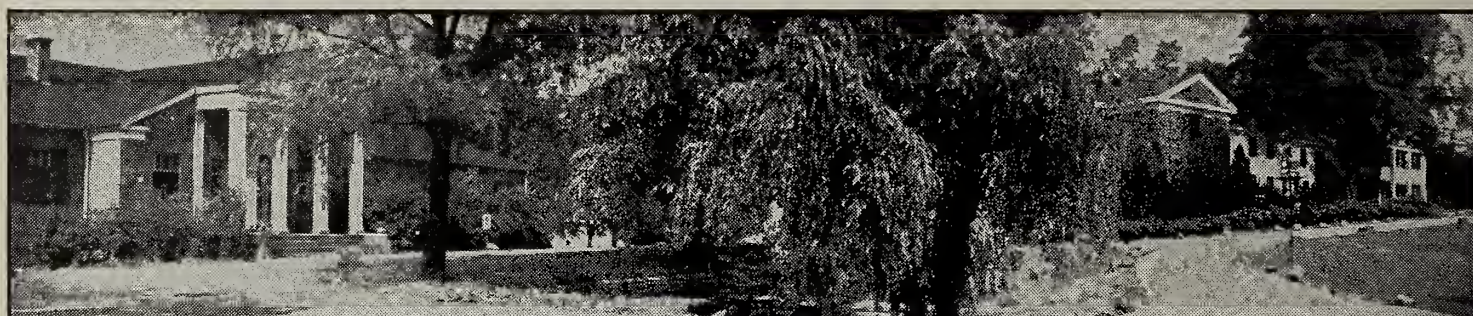
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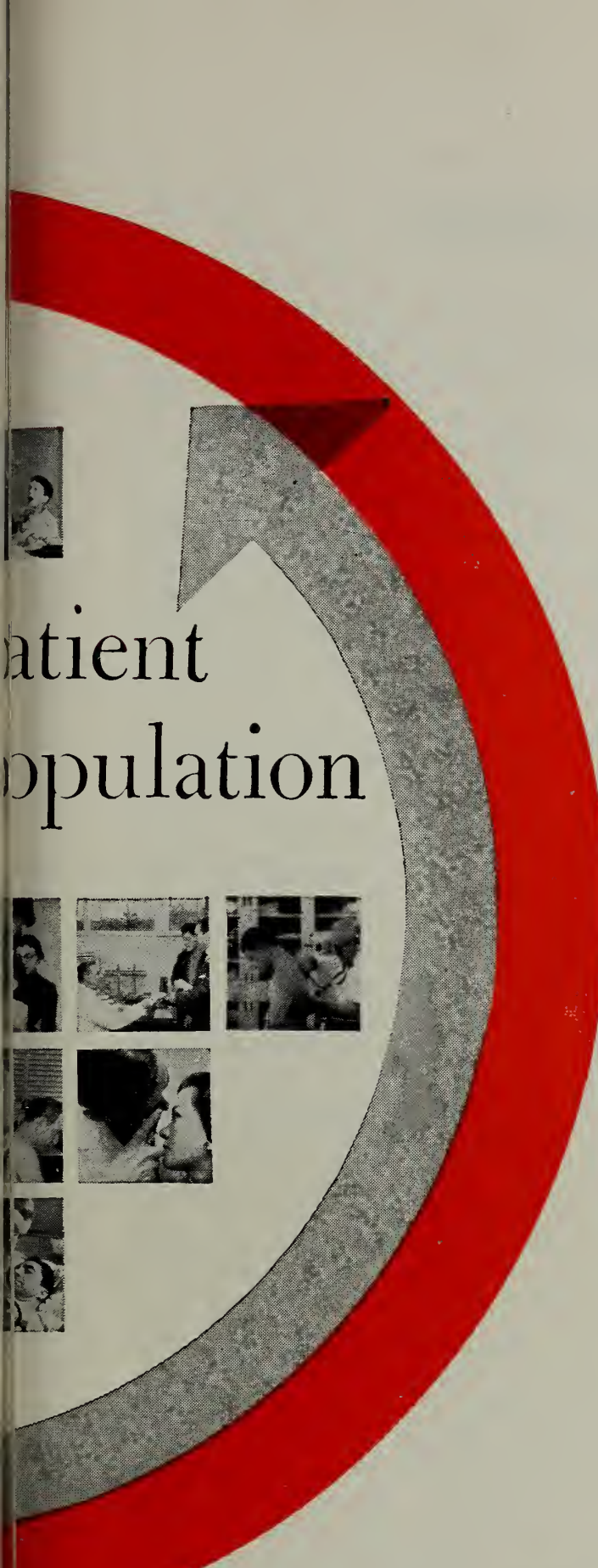
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The Physician's Bookshelf

By JONATHAN FORMAN, M.D.

Symposium on Atherosclerosis, Medical Division National Research Council at the request of The Human Factor Division of the Air Force Directorate of Research and Development. (\$2.00. *National Research Council, 2101 Constitutional Ave., Washington 25, D. C.*) A major problem of the Air Force is human capacity to withstand stress, fatigue, and aging. As finally constituted, however, this symposium extends well beyond the lipoproteins its original framework, and even considers processes other than atherogenesis.

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The Happy Child, a Psychoanalytical Guide to Emotional and Social Growth, by Irene M. Josselyn, M. D. (\$3.95. *Random House, New York 22, New York.*) Any parent using this handbook to learn how children develop, and at the same time giving them an abundance of love, can hope to achieve success in the raising of a happy family.

The County Nurse, by Maude MacCurdy Welch, (\$2.50. *Avalon Books, New York, N. Y.*) This novel tells the story of a Missouri county nurse with a match-making and incurably romantic aunt. When she meets the train on which an elderly doctor is supposed to arrive, she is flabbergasted to find instead a handsome young doctor from St. Louis. What with the doctor and the aunt, she cannot call her home her own. How Patsy wakes up to the truth of the situation and the solution of a long-standing mystery makes an exciting end to an appealing story of a stubborn young Missouri nurse.

The Truth About Cancer, by Charles C. Cameron, M. D. (\$4.95. *Prentice-Hall Inc., Englewood Cliffs, N. J.*) The Medical and Scientific Director of the American Cancer Society tells us everything practically useful about cancer. It is a book of reference with which to gain an understanding about the different kinds of cancer, their natures, diagnoses and treatment.

Nutrition Practices: A Guide for Public Health Administrators. (\$1.00. *American Public Health Association, 1790 Broadway, New York 19, New York.*) A Committee of the Society spent two years studying the responsibility of public health officers anywhere to include education concerning nutrition. Our own Carl A. Wilzbach was one of this committee and the others are all of equally high stature.

A Textbook of Clinical Pathology, edited by Seward E. Miller, M. D. (\$11.00. *Williams and Wilkins Co., Baltimore 2, Md.*) There are 10 well-known contributors to this text including the editor of *The Journal's* CPC's—Emmerich von Haam, of Ohio State University. It proposes to give the interested reader an authoritative source of information on how to use the clinical laboratory most advantageously. It therefore is a work of reference for all who practice medicine. It certainly deserves a place in the library of every resident staff.

Hypotension: Shock and Cardiocirculatory Failure, by Paul G. Weil, M. D., Ph. D. (\$2.25. *J. B. Lippincott Co., Philadelphia 5, Pa.*) The Director of the Transfusion Service at the Royal Victoria Hospital in Montreal has written the Pocket Book for physicians. What to do for shock is re-emphasized although its occurrence and much of its mechanism are well understood today. Many new facts concerning hypotension from laboratory and clinical experience have accumulated in recent years. They are brought together for the first time.

Symposium on Protein Metabolism, The eighth sponsored by *The National Vitamin Foundation, Inc., 15 E. 58th St., New York 22, N. Y.* (\$1.00.) This booklet deals with vitamin B₁₂; role of vitamins in antibody production; growth hormones; amino acid requirements; their utilization in protein synthesis and their use in therapy.

Counseling in Medical Genetics, by Sheldon C. Reed. (\$4.00. *W. B. Saunders Co., Philadelphia 5, Pennsylvania.*) Many physicians are frequently asked about some genetic problem. The patient does not know how inadequate the knowledge of most physicians is in these matters. Few physicians have the time or the facilities to search through the score of publications for the facts. The Director of the Dight Institute for Human Genetics at the University of Minnesota has done this for us in this book. Twenty-nine chapters in all treat of malformations, retardation, pyloric stenosis, disputed paternity, allergies, psychoses, diabetes, and many other conditions in the light of modern knowledge concerning inheritance.

The Facts of Life, by Cyril Dean Darlington. (\$7.00. *Importations Dept., The Macmillan Co., New York 11, N. Y.*) This book begins as a history of man's attempt to discover the facts about himself and goes on to deal in detail with heredity, sex and reproduction, and with their bearing on the great problems of society—with race, class and mating; with education, health, and crime; with evolution and our interpretation of history; and the never-ending war between

what we know and what we would like to believe. The Sheradian Professor at Oxford comes up with a philosophy of determinism which is not new—at least so far as the name goes, but, the evidence upon which the author bases his case has been brought together since World War I. The result therefore is in fact a new philosophy of life.

The Physician and the Law, by Rowland H. Long. (\$5.75. *Appleton-Century-Crofts Co., Inc., New York, N. Y.*) A text book on forensic medicine from the medical viewpoint.

Diagnosis and Treatment of the Acute Phase of Poliomyelitis and Its Complications. Edited by Albert G. Bower. (\$6.50. *Williams and Wilkins Co., Baltimore 2, Md.*) Fourteen contributors have teamed together to produce this manual. It is based upon their combined experiences with over 17,000 cases seen at the Los Angeles County Hospital.

New Outlook on Mental Diseases, by F. A. Pickworth, M. B. (\$12.00. *Williams and Wilkins Co., Baltimore 2, Md.*) This work shows how the brain integrates the cells of the body but disputes its accepted role as the seat of the mind. The author insists the patterning of blood-flow in the cerebral tissues determines the pattern of association of somatic tissues and this conditioning of reflex pathways for sensori motor activities proves a satisfactory basis for correlating mental and medical phenomena. The author was formerly director of the Joint Board of Research for Mental Disease in Birmingham.

Dentistry in Public Health, edited by Walter J. Pelton, D. D. S., M. S. P. H., and Jacob M. Wisan, D. D. S., M. S. P. H. (Second Edition. \$6.50. *W. B. Saunders Co., Philadelphia, Pa.*) A survey of a relatively new field in public health work and public education is given successful treatment here by 10 authorities. Administration and Survey Programs, Dentistry Needs, Health Education and Dental Economics, are all given consideration in separate chapters.

Mechanisms of Microbial Pathogenicity: The Fifth Symposium of the Society for General Microbiology, edited by J. W. Howie and A. J. O'Hea. (\$5.00. *Cambridge University Press, New York, N. Y.*) The invasion of one organism by another may be followed by disturbances of function, metabolism, toxemia, visible lesions and death. The object of this symposium with its 16 papers by 18 outstanding British and American students of infection is to focus attention upon the mechanisms by which the invading individual organism produces such unfavorable effects upon its host to the detriment of both.

Plants, Man, and Life, by Edgar Anderson. (\$4.00. *Little, Brown and Co., Boston, Mass.*) This book tells of the investigation over a period of years of the assistant director of Missouri Botanical Gardens. He tells in a popular fashion

how and where plants came into the life of man, that may have even come into being under our influence and yet have in the end shaped the destiny of man. With this data from his researches and that of others, Anderson wrote the history of mankind.

1955: Medical Progress, edited by Morris Fishbein, M. D. (\$5.00. *McGraw-Hill Co., New York 18, New York.*) Presents the progress in Medicine under the editorship of the brilliant and experienced Morris Fishbein. Exactly 20 chapters—each one a complete essay by one of the better known medical teachers.

Science and the Human Imagination: Aspects of the History and Logic of Physical Science, by Mary B. Hesse. (\$3.75. *Philosophical Library, Inc., New York 16, N. Y.*) The author is Lecturer in Mathematics at the University of Leeds. She justifies her work in these words: "In recent years study of the history and philosophy of science has tended to show that the historical relations of science and Christianity need some reinterpretation; and that, on the philosophical side, the theories of science are not to be taken for granted as literal statements of fact, but that questions about their truth, meaning and logical status are very open questions to which some tentative answer must be given before there can be any discussion about their relation to religion."

Antisera, Toxoids, Vaccines and Tuberculin in Prophylaxis and Treatment, by H. J. Parish, M. D. (3rd edition, \$5.00. Published for Wellcome Foundation by *Williams and Wilkins Co., Baltimore, Md.*) It is a review of a book written to present in convenient form, the essential principles of immunology and their practical application to human medicine.

Enzymatic Concept of Anaphylaxis and Allergy, by Z. Z. Godlowski, M. D. (\$3.50 *E. & S. Livingston, Ltd., Edinburgh and London*; United States distributor, *Williams & Wilkins Co., Baltimore, Maryland.*) The author has spent many years of research on problems that at first glance do not appear to be related—the effect of insulin shock on the suprarenal cortex; the occurrence of eosinophils; and, later, their relation to antigens and lastly, the interrelationships of suprarenal cortical hormones, eosinophils, and lymphocytes. These are now assembled here to explain on an enzymatic basis the complexities of allergy and immunity.

Better Homes and Gardens Diet Book. (\$2.50. *Meredith Publishing Company, Des Moines, Iowa.*) This is not the usual book with its rigid rules but rather a complete year-round diet and nutrition guide for the underweight, the fat and the happy "normals" too.

The Nature and Significance of the Antibody Response, Alwin Pappenheimer, Jr., Editor. (\$5.00. *New York Academy of Medicine, Columbia University Press, New York 27, N. Y.*) Here are

discussed the current ideas concerning the formation of antibodies, their nature, and their role in allergic diseases. Emphasis is placed throughout on the biologic significance of unusual reactions.

Experimental Psychology. (\$2.75. *Philosophical Library Inc., New York, N. Y.*) This is a series of six broadcasts of BRC by experimental psychologists, A. J. Watson, Harry Kay, J. A. Deutsch, B. A. Farrell, Michael Argyle, and R. C. Oldfield. The series is intended to show what is going on at the present time and to exhibit the general attitude of these investigators toward their results.

Practitioners Conferences: Held at New York Hospital—Cornell Medical Center, Volume I, edited by Claude E. Forkner, M. D. (\$6.75. *Appleton-Century-Crofts, Inc., New York, N. Y.*) Fourteen of these conferences have been selected and presented as a part of the educational program of Cornell University. They will prove very informative and instructive to any physician who will read them.

American Sanatorium Association—A Brief Historical Sketch. (Apply. *National Tuberculosis Association, New York, N. Y.*) This story follows closely the Association's past without the burden of detailed proceedings and countless reports.

Keep Your Hair On, by J. George Fredericks. (\$2.00. *Rudolph Field Company, 5 Columbus Circle, New York 19, N. Y.*) Argues for good personal hygiene, good diet, adequate exercise and good care of the hair. The author calls for frequent washing, and brushing regularly. Guard your combs and brushes, massage the scalp at least once a day. Do not wear tight hats, or any night caps. Stay away from super soft pillows. Avoid all hair restorers and scalp lotions. These and many other suggestions are gone into in detail.

Introduction to Chemical Pharmacology, by R. B. Barlow. (\$6.25. *John Wiley & Sons, Inc., 440 Fourth Ave., New York 16, N. Y.*) The relation of chemical structure to physiological action has fascinated organic chemists for years. Their problem belongs of course to the pharmacologists. The author tries to bridge the gap between them, the biochemist, and the chemist insofar as our knowledge will permit.

The Johns Hopkins Hospital School of Nursing, 1889-1949, by Ethel Johns and Blanche Pfefferkorn. (\$4.50. *Johns Hopkins Press, Homewood, Baltimore 18, Maryland.*) The Alumnae Association of the School set about to produce a listing of their school in 1946, and so a committee was appointed. This committee gave untiringly of their time and energy. Two nurses with experience as writers were set at the task of bringing the data they collected into book form in the hope that the information thus assembled might be a real contribution to nursing. The book is therefore one

that is a "must" for all who are interested in the history of nursing and should be in the library of every School of Nursing. It is a great pity that most R. N.'s know nothing of the background of their profession, only that which occurred in their hospital in their student days.

The Relief of Symptoms, by Walter Modell, M. D. (\$8.00. *W. B. Saunders Co., Philadelphia 6, Pennsylvania.*) The author points out that today patients are offered more and prompter relief than that which is incidental to the treatment of the disease. The use of such drugs to bring prompt relief while the physician goes on about his work of treating the disease rests upon the contention that the symptoms *per se* may be a malignant force and therefore should be taken care of and gotten rid of, if possible. Consequently, the author insists that the symptom and the problem of its relief should be given as much thought as it deserves in relation to the importance to the particular patient, his reactions to distress, the effects of distress upon his disease and his function state. With this he discusses 23 different major symptoms with a full essay on cortisone and the masking of symptoms.

The Biological Effects of Tobacco, edited by Ernest L. Wynder, M. D. (\$4.00. *Little, Brown and Company, Boston, Mass.*) The first complete analysis of a subject vital to the race by eight authorities covering every phase of this controversial question. Incomplete as our knowledge is, Joseph Garland, the editor of the *New England Medical Journal*, says in his introduction, "The available information is enough on which to make a rough evaluation of some of the risks in using tobacco."

"Many producers of tobacco still cling to the illusion that it is harmless despite the evidence to the contrary and rather naïvely advertise the use of filters to remove substances, the toxicity of which they are unwilling to admit."

Since at the recent mid-year meeting of the A. M. A., Dr. Irving Schuller and his associates presented evidence that cigarette smoking was not only related to peptic ulcer and cancer of the lung but also was often the cause of chronic emphysema and Drs. Overholt and Bougas called upon the doctors to stop smoking as an example, every physician owes it to himself to get the best information available. Here it is summarized for him.

Progress in Allergy, edited by Paul Kallos. (\$20.00. *Little Brown and Co., Boston, Mass.*) This work contains eight long and comprehensive discussions of the work in eight different aspects of allergy. They deal with the immunologic and experimental work that has been done. Paul Erlich first attributed the specific activity of antigen and antibody to definite chemical structures. All will recall how he represented these structures by the familiar "lock and key" type

(Continued on Page 1270)

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References: 1. Boland, E. W., *J.A.M.A.* 160:613, (February 25,) 1956. 2. Margolis, H. M. *et al.*, *J.A.M.A.* 158:454, (June 11,) 1955. 3. Bollet, A. J. *et al.*, *J.A.M.A.* 158:459, (June 11,) 1955.

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Psychoanalysis—Practical and Research Aspects, by Willi Hoffer, M. D., Ph. D. (\$3.50. *Williams & Wilkins, Baltimore 2, Md.*) This is the 12th in the series of Abraham Flexner Lectures by the editor of the *International Journal of Psychoanalysis*. The distinguished London worker brings to these five integrated lectures great practical experience and a wealth of academic training. Consequently his view and observations both on empirical and scientific sides of his own work make this a most interesting book well worth reading even by a skeptic such as your reviewer happens to be.

Mr. Carlyle My Patient, A Psychosomatic Biography, by James Halliday. (\$3.50. *Grune & Stratton, Inc., New York 16, N. Y.*) All of the patient's pains and complaints are analyzed in terms of his relation to his environment. It makes a fascinating story when told in these terms.

The Lung, Clinical Physiology and Pulmonary Function Tests, by five authors. (\$5.50. *Year Book Publishers, Chicago 11, Ill.*) Julius Comroe, Robert Forster, Arther DuBois, William Briscoe and Elizabeth Carlsen of the Graduate School of the University of Pennsylvania have combined to produce this book, based on the 1954 Beaumont Lectures. Most of the literature in this field is over the heads of us physicians but this is not; it has been written for us that we may understand in a practical way such concepts as ventilation, blood flow ratios, diffusing capacity, physiological dead space, distribution compliance alveolar ventilation or transpulmonary pressure.

Karl Marx and Frederick Engels on Malthus—Selected Readings, edited with an introductory note by Ronald L. Meek. (\$2.25. *International Publishers, New York 16, N. Y.*) To mention Malthus today always produces much heat and hair splitting but few know or care what Malthus tried to say. They go on arguing for their cause on the basis of what they think he said or meant. All that Malthus really tried to say was that poverty was inevitable unless the poor restricted their own multiplication. Some claim therefore that his theories live on today in the make-shift plans of J. M. Keynes. Those who use the possibility of population pressure producing food crises to bolster the arguments in favor of soil and water conservation are here accused by the editor in his introductory essay of using Malthus' theories in the services of the cold war and of imperialism.

The selections, from the writings of the Messiah of Communism and Socialism take issue with the theory of diminishing returns which the "Neo-Malthusians" today use to prove that social changes cannot eliminate the shortage of food.

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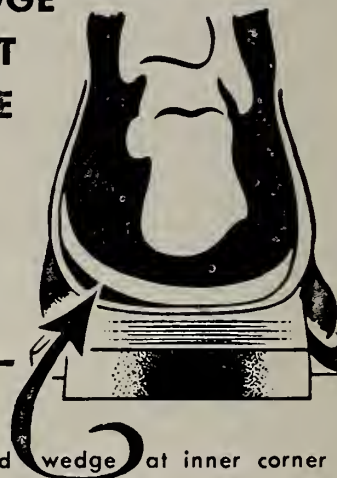
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Vol. 52

December, 1956

No. 12

JONATHAN FORMAN, M. D., *Editor*

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Bacterial Allergy—A Review

HERMANN BLATT, M. D.

THE purpose of this paper is to report on 10 years study of bacterial allergy using as a tool the test which Dr. F. A. Nantz and I^{1, 2, 3, 9, 10} developed in 1946 and on the therapeutic results which I have obtained by using the specific bacterial filtrates found by the test to be the patient's bacterial allergens.^{4, 5, 6, 7, 8}

Allergy, or hypersensitivity, to micro-organisms is not a new concept. Descriptions of the symptoms and reactions and recommendations of palliatives and "cures" are to be found in the earliest medical writings and have been given a surprising proportion of medical attention ever since. Until the research of the past 50 years, however, little was known of the cause, and we are only beginning to understand something of the nature of the mechanism by which the hypersensitive or allergic state is established.

TWO TYPES OF ALLERGY

In allergy we distinguish between two types of reactions: The *immediate* (or *atopic* or *anaphylactoid*) type which takes place shortly, within minutes, after the introduction of the antigen, and the *delayed* (or *tuberculin-like*) type which appears after some hours.

This distinction has caused considerable controversy. It is generally agreed that: (1) Both types of response can be elicited only after an incubation period following the sensitizing introduction of the antigen; (2) Both are specific, i. e. an antibody reacts most fully to its specific or homologous antigen, but may react with other antigens with similar but not identical molecular arrangements; (3) Both respond favorably to desensitization; (4) Both have the so-called anamnestic reaction, i. e. after hypersensitivity has completely

The Author

● Dr. Blatt, Cincinnati, is a member of the staff, Jewish Hospital.

subsided, if the antigen is reapplied, hypersensitivity reappears much more readily than originally.

There are, however, some important differences in addition to the difference in reaction time. In tuberculin allergy: (1) No humoral antibodies have been demonstrated in the blood serum. In other words, the hypersensitivity cannot be transferred by injecting the serum of the allergic animal into a nonsensitized animal; i. e. the serum of an allergic individual injected into a normal subject does not make the normal subject give a positive wheal reaction to a skin test at the site of injection.

(2) The white cells of the blood are damaged by the filtrate from the specific bacterial strain to which the individual is sensitized. Rich¹⁷ demonstrated this phenomenon in tissue cultures of the spleen using Old Tuberculin. This can be shown in the avascular cornea of an experimental animal. A patient's bacterial allergens can be identified by suspending his white blood cells in the filtrate of the specific strain which is his offending organism.

(3) There is not a particular observable reaction in the so-called shock tissues, such as the smooth muscle or the blood vessels.

(4) No H-substances, such as histamine, are released, and no other intermediary factors are known to exist.

(5) There is considerable evidence that certain factors may be requisite for sensitization. They

may be physical and/or nutritional, but they are not genetic, as they are thought to be in atopic allergy.

SCHOOLS OF INTERPRETATION

The Unitarians grant these points but feel that fundamentally the only difference between the delayed and immediate reactions "lies in the route taken by the antigen and hence the rapidity with which it reaches the shock organs."

Godlowsky¹⁷ and his school believe that in all types of allergy two independent reactions are concerned. The first is an antigen-antibody reaction, which may take place in the fluids within the cells themselves. This action defends the body from harm by invasion. If this mechanism fails, then sensitization takes place. The overpowering antigen induces the formation of a specific proteolytic toxic enzyme system. This is the mechanism of sensitization. Subsequent invasions of the antigen cause toxic proteolysis and liberates various proteoses. These, in turn, activate normal nonspecific proteinases and thereby start a chaotic chain-reaction lysing the host's own protein. The toxins produced by this proteolysis cause the local and constitutional manifestations.

A growing number of workers are becoming convinced that the two types of allergy are independent, that a patient may develop either or both types of hypersensitizations to a micro-organism, and that he may become desensitized to the one type while retaining the other. Adherents of this school ascribe much of our difficulty in understanding these phenomena to the fact that the two types are being confused.

The tuberculin type is generally regarded as the one most often responsible for the chronic symptoms caused by micro-organisms. The only method of diagnosis up to now has been the delayed skin test, i. e. the tuberculin test. It is when the delayed skin test is negative that the Blatt-Nantz test makes its most important contribution to the management of the patient with a possible bacterial allergy. A negative skin test is of frequent occurrence. Less often, and generally only during a short period following an infection by the organism, a positive skin test may be found when the Blatt-Nantz test is negative. Positives for both skin test and the Blatt-Nantz test are to be expected when the patient has a severe chronic focus of infection.

Some grant the usefulness, even desirability, of using this clear-cut distinction between the two types of allergy in assaying and investigating any clinical results. Forman¹⁸ finds it especially valuable with elderly patients, where he quite frequently gets no skin reaction at all, but is able to get good results using the Blatt-Nantz technique.

Nevertheless, the exact role which allergy plays in infections, especially of the chronic type, is still controversial. Swineford¹⁹ made over 5,000 in-

tracutaneous skin tests with 34 crude polysaccharides and nucleoprotein fractions of 14 different bacteria. Many immediate and delayed reactions were obtained, but he was unable to find any relationship between the disease manifested and the positive tests.

RELATION OF ALLERGY TO IMMUNITY AND NUTRITION

Patients known to be sensitized to a bacterium are more susceptible to invasions of that bacterium than are normal individuals. This is accepted as a truth though it has never actually been proven. The similarities between the courses of a patient's succeeding infections are accepted as adequate basis for this assumption. Proof would require that the strains of bacteria in both instances be known to be identical. That probably must await a simple method of classifying strains. All that now can be done is to see that the dominant organism of each succeeding infection belongs to the same family.

Some say allergy is a phase in the direction of immunity. But this is challenged. Rich¹⁷ and many others point out that immunity is a protective process, which is *beneficial*, whereas bacterial allergy produces an inflammatory and necrotic state of the tissues, which is *harmful*. Raffel, Coons, and others¹⁷ have been studying the alpha, beta and gamma globulins and the lymphocytes and leukocytes in the hope of determining the mechanisms of immunity and allergy.

Recently attention is being given to observations of specific nutritional deficiencies accompanying allergy in patients who are unusually sensitive to infection, i. e. have lost their immunity to the invader. Some observations point to a casual, others to a consequential relationship between nutritional deficiency and allergy and susceptibility to disease.

DIAGNOSIS AND TREATMENT

In clinical practice there has been little recognition of the role played by microbial allergy. This is no doubt due to the fact that none of the investigation has as yet given tools to the physician with which he can successfully treat his patients. Until it can offer him something practical, interest will lag. The work of Rich, monumental though it was, did not provide the physician with a method of diagnosing and treating patients, but it did give us an indication of the underlying mechanism of sensitization.

Vaccines, both stock and autogenous, have been widely used for the past 50 years, but on an empirical basis. Their proponents often did not associate them with Rich's work. Even many allergists were slow to use them to attempt to overcome an allergy to them, but continued to use them in an attempt to create an immunity. Physiotherapies, chemotherapies, dietary restrictions and supplements, antibiotics, and even psychiatry were considered by many to be of greater value.

Perhaps no one as yet has been able to make vaccines that consistently included all of a patient's microbial allergens.

Physicians have, nonetheless, continued to use vaccines and often accomplish the unexpected desensitization to the allergy. Rose¹⁷ uses both stock and autogenous vaccines and filtrates. He has pooled vaccine from persons in the local area having chronic or recurrent respiratory infections with or without associated allergy. Baird¹⁷ uses "serobacterin," a sensitized vaccine. This vaccine contains no serum but has both bacterial antigen and antibody in contrast to most commercial preparations. He attributes his success to his giving larger doses than those recommended by the manufacturer. Heise¹⁷ believes that the long-chain Streptococci are the ones most responsible for bacterial allergies of the upper respiratory tract. With clinical improvement they disappear from the smears.

ACTH, cortisone and similar steroid products today play an important role in the modern treatment of bacterial allergies. Their effects, however, are palliative and transient, accomplished as they are by suppressing inflammatory reactions. These steroids are also diagnostic of the allergic nature of the clinical manifestation. Antihistamines too are used as a diagnostic tool.

In all bacterial allergies, we rely entirely on our own test and treat with the same filtrates which give positive reactions. Treatment is continued until the patient's white cells no longer show a positive reaction to his offending microbes.

DIAGNOSIS BY CLINICAL MANIFESTATION

It is not too difficult to recognize bacterial allergy clinically. There are a great many indications of its presence; the more that are present in any one case, the more likely that the diagnosis will be established and good results obtained by specific desensitization. Some of these indications are:

1. A history of frequent recurrence of infection, particularly if they are seasonal in occurrence.
2. Exacerbations following certain infections.
3. A sedimentation rate regularly elevated, however slightly.
4. A temperature slightly below normal or, less commonly, slightly above normal.
5. A red cell count regularly somewhat below normal.
6. A white blood cell count regularly abnormal.
7. A differential white count deviating from normal. An excess of eosinophils may be helpful in the diagnosis of an allergy, but not necessarily of a bacterial allergy.

TECHNICAL DIAGNOSIS

Technically, microbial allergy is characterized: (1) By a history of or the presence of an infec-

tion, perhaps followed by a relapse or a prolonged recuperation; (2) In a certain percentage of cases, by positive skin tests using specific vaccine or extracts of the bacteria, or with filtrates of their metabolic products; or (3) by the necrotizing power of the same filtrates upon leukocytes of the patient in tissue cultures or *in vitro* suspensions. This last fact is the basis of our Blatt-Nantz test. This test uses Rich's observation that the blood cells of bacterially sensitized subjects are damaged or destroyed when subjected to the products of those bacteria.

The white blood cells obtained from the coagulated Buffy coat are incubated with the numerous bacterial filtrates and then observed microscopically for morphological changes some 17 hours later.

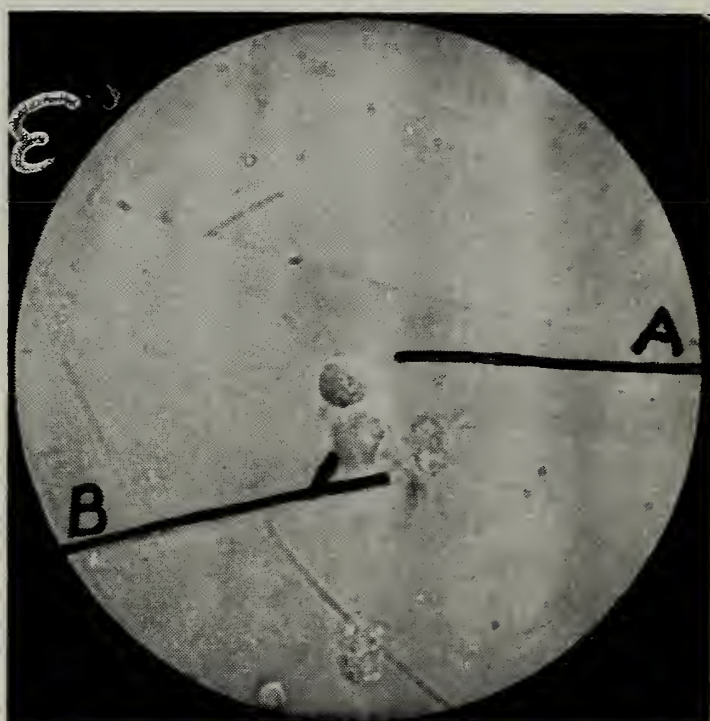


Fig. 1. Photomicrograph, Blatt-Nantz test, showing (A) unaffected viable leukocytes, and (B) necrotized leukocytes.

Routinely a carefully selected collection of about 125 filtrates of different strains of bacteria is employed. Additional ones are added as the medical history indicates. Tests are also run to filtrates of the patient's autogenous cultures. Any strains producing positive reactions are always tested three times more to rule out false positives, which do occur. The same filtrates which produce positive reactions are then diluted and used for desensitization injections. This is an arduous procedure. The actual test takes the time of two technicians for the greater part of two days. This does not cover the preparations of filtrates, the processing of glassware and other "incidentals." The tests therefore, are run only when the clinical observations and medical history indicate that they are likely to yield results.

ANTIBIOTIC COMBINED WITH FILTRATES

For the past few years,¹¹ to some patients we have administered oxytetracycline (terramycin®) and tetracycline hydrochloride (tetracycl®) con-

comitantly with our specific filtrates. This hastens the desensitization process apparently by controlling the infections.

CLINICAL APPLICATIONS

Asthma. In the development of bronchial asthma in the older patient, microbial allergy frequently plays the major role and, when it does, specific desensitization is especially helpful.^{12, 13, 16} In asthmatic children, when the attacks invariably accompany an upper respiratory infection, Peshkin¹⁷ warns that microbial allergy should be suspected. Some argue that in children such asthmatic attacks are pure infection. Here it is important to be right. Infection requires an immunizing or large dose of vaccine, while allergy requires a desensitizing or small dose. To give an allergic person too large a dose can severely aggravate his symptoms!

Rheumatic Fever. In World War II Coburn established incontrovertibly that this disease is a hypersensitive state which occurs 3 to 20 days following an upper respiratory infection. Swift¹⁷ elicited a tuberculin type response to hemolytic Streptococci, and Traut¹⁷ found that "Patients with ancient rheumatic fever and chronic arthritis reacted positively to intradermal injections of many different kinds of Streptococcus derivatives far exceeding controls."

Most agree that the disease is the hypersensitive response of the mesodermal tissues to the organism. Coburn¹⁷ thinks the response is to chemical substances originating in the inflammation. Antistreptolysins, agglutinins, complement fixing antibodies and C-reactive proteins have been demonstrated in the blood of patients. Rheumatic fever, being a collagen disease, its establishment as a microbial allergy made researchers suspect all collagen diseases might be allergies. Since Coburn's reports, pediatricians have been very careful to clear up all sore throats as quickly as possible with the new "miracle" drugs. In consequence there have been fewer new cases of rheumatic fever.

Rheumatoid Arthritis. The role of allergy in this disease is not universally conceded despite its inception during infection and its accompanying low-grade fever, elevated sedimentation rate, leukocytosis, lymphadenitis and the involvement of the joints.¹⁷ Many patients have high agglutinins and positive skin reactions to hemolytic Streptococci and some have had Streptococci demonstrated in their blood. Freiberg¹⁷ produced arthritic joint lesions in animals with repeated injections of bacterial filtrates. Clinicians report flare-ups after injecting minimal doses of Streptococci and the recession of symptoms following desensitization.

Otolaryngology. Few allergic manifestations involving the external ear canal, auricle and postauricular area are caused by bacteria, although Streptococci or Staphylococci may pro-

duce them. Many draining ears are caused by sensitization to bacteria recovered from the middle ear infection and clear up with autogenous vaccine. Kuhn¹⁷ finds that 2 per cent of hearing difficulty cases are definitely of allergic origin. A few cases of Meniere's disease are also instances of bacterial allergy. Endolymphatic hydrops is frequently on an allergic basis. The few coming under my observation have been mixed allergies, i. e., the patients were sensitive to bacteria and to pollens or other inhalants and occasionally to foods.

Nasal Allergy. Forman¹⁵ emphasizes the frequency of microbial allergy in cases of chronic nasal infection and nasal polyp, especially if the skin tests to atopens are negative and there is no familial history of atopic allergies. Microbial allergy is frequently suggested by a thick, yellowish postnasal drip, congested nasal turbinates, haziness of the sinuses, and the first attacks following fall or winter colds, perhaps associated with low-grade temperature.

Ocular Allergy. Conjunctivitis is commonly allergic, often to a toxin producing Staphylococcus, though most any microbe can be the allergen. Woods¹⁷ always suspects a microbial allergen when a chronic nonpurulent conjunctivitis is associated with either folliculosis, marginal blepharitis or reddened swollen margins of the lids. The tissues of the eyes can readily be sensitized by bacterial products from local, nasal or more distant infection. The diagnosis can be most difficult, as for example in iridocyclitis, chorioretinitis and iritis. Woods finds the nongranulomatous form of recurrent uveitis and iritis to be an allergic reaction, usually to a Streptococcus, and gives a specific vaccine.

Berens¹⁷ warns that it is difficult to find the specific bacteria or their products in lesions of the uveal tract and that it may, in fact, be dangerous to demonstrate hypersensitivity to organisms in the eyes. Skin or white-blood-cell tests are safer. When Berens finds coliform organisms in cultures of the feces or the respiratory tract, he feels the patient will improve more rapidly to desensitization than to any other type of treatment. Castroviejo¹⁷ reported pathology in the paranasal sinuses in patients having diseases of the cornea and lens. Autosensitization to damaged uveal pigment of one eye apparently is a predisposing factor for the development of sympathetic ophthalmia. Ocular tuberculosis may not always be an allergic manifestation but certainly some cases are.

Hives. Drugs are the most frequent allergens in urticaria and angioedema, but some cases are bacterial allergy.¹¹

"Ids." Some dermatologists restrict "id" to fungus sensitization, but others, like Leider,¹⁷ use it in a broad sense. Urbach and Gottlieb¹⁷ define an "id" as the morphologic response of a highly sensitized skin to bacterial or toxic agents emanat-

ing from a remote focus of infection, or to substances from an allergic tissue, carried to the skin by a hematogenous route. The "id" lesions themselves are almost invariably free of microorganisms, but the skin has a marked specifically altered reactivity to products of the offending bacteria applied locally. Bacterids cause generalized eruptions confined usually to the extremities and the trunks. The papules are small, follicular, acuminate or flat reddish at first, and may have a small vesicle, pustule or scale. Only occasionally does a bacterid simulate a lichenoid exanthem or other forms of eruption.

CONCLUSION

It is apparent from a survey of the literature that many, if not all, cases of truly intrinsic allergy are instances of bacterial allergy. The confusion which still exists on this point revolves around the tests and especially the criteria used to establish the identity of the causative agent. We have satisfied ourselves, after 10 years of experience with the Blatt-Nantz test, that bacterial allergy not only plays an important role in certain patients with allergic manifestations, but in many instances of intrinsic allergy, it is the primary underlying mechanism.

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All other references in this article are to be found in the bibliography attached to the recent review:

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KEEPING UP WITH MEDICINE

• THE RECENT suggestion in this column from well known authorities that diamox® "appears to have a special place in the treatment of cor pulmonale" raised the question of respiratory acidosis in the mind of Constantine Vishnevsky, M. D., of Canton, Ohio. He writes,

"Patients with cor pulmonale are in respiratory acidosis. By giving acetazoleamide (diamox®), which is a carbonic anhydrase inhibitor, we intensify the acidosis by developing metabolic acidosis in addition to respiratory acidosis. Consequently, in cor pulmonale diamox® often contributes to the deterioration in patient's condition. This subject was the topic of a panel discussion on cor pulmonale at the meeting of the College of Chest Physicians in June, 1956, in Chicago and the participants were unanimous as to the dangers and inexpediency of the use of diamox® in cor pulmonale. I may also refer to M. Galdston's paper in the October, 1955, Volume 19, pages 516-532, of *The American Journal of Medicine*, on the same subject."

* * *

• THE STUDIES at the Ohio Penitentiary on 14 volunteers have shown that well persons have some kind of a natural defense against cancer. When cancer is transplanted into another human being there is always a vigorous rejection reaction. In cancer patients, on the other hand, such rejections do not occur.

* * *

• ABOUT 1500 DEATHS a year are now caused by a motorist falling asleep at the wheel.

* * *

• MAN MUST LEARN to live and work with machinery. But with the introduction of mechanization the farmer no longer takes the rest period his father did with the team of horses and so he is increasingly becoming involved in accidents. A mid-morning break and one in the afternoon is recommended for the farmer as well as the factory worker.

* * *

• IT SEEMS unlikely that we shall be able to add much to the length of the average life by preventing deaths before 42. If all deaths before 42 were to be prevented, the life expectancy of the people of U. S. A. would lengthen by only 4.5 years.

* * *

• DECOMPOSITION of chlorophyll, upon which all life depends, gives rise to substituted pyrroles very like those obtained from heme.

* * *

• RECENT WORK suggests that patients with hyperlipemia have a deficiency of the enzyme lipoprotein lipase that breaks down large fat molecules in the blood and thus helps to transport them. This condition has been found in certain cases to be congenital.—J. F.



MATERNAL HEALTH IN OHIO

A CONTINUOUS state-wide Maternal Mortality Study is being conducted in Ohio by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health and assisted by official representatives of the various County Medical Societies of the state.

Since work of the committee is educational as well as statistical, summaries of some of the cases studied by the committee, based on anonymous data submitted, will be published in *The Ohio State Medical Journal* from time to time. Each presentation will be brief but informative. It will contain opinions of the committee, based on the data submitted for review. This fourth report opens a series of cases, entitled "Other Causes," in which the following three cases are maternal death due to anesthesia.

CASE NO. 10

This patient was 38 years old, white, Para V, abortus I, who died three hours postpartum. Her past history was not remarkable; the first two pregnancies went to term and were delivered without event except that both were monstrosities and were born dead. The third pregnancy was spontaneously aborted at 12 weeks, while the fourth and fifth went to term and were delivered normally, alive, and without abnormality.

The last (sixth) pregnancy was uneventful; prenatal care was considered adequate with nine visits. Serologic test for syphilis was negative, Rh-positive, both tests taken in the fourth month. Labor began spontaneously at 42 weeks gestation and the patient was admitted to the hospital when the cervix was almost completely dilated; on admission she was markedly excited, nearly to the point of hysteria. Demerol® 100 mg., and scopolamine 1/150 gr. were administered; later nitrous oxide-oxygen anesthetic was instituted along with 6 cc. of a 2½ per cent solution of sodium pentothal® intravenously. The excitement continued and she was given another 6 cc. of sodium pentothal® slowly. Before the injection was finished the patient had apparently aspirated an appreciable amount of gastric juice and solid material. She was cyanotic and apneic; some of the substance was removed, and delivery was accomplished hurriedly (low forceps and episiotomy) delivering a living 8 pound, 7 ounce baby.

Details of the third stage of labor were not reported. Although the patient's color improved (postpartum), she failed to respond. An internist and chest surgeon were called in consultation. A considerable amount of frothy liquid continued "to escape"; a laryngoscope and bronchoscope were inserted to remove additional material, but the frothy liquid continued to run out of the instrument in abundance. Her condition grew progressively worse until her death, hours later. There was no autopsy.

Cause of Death: Delivery, anesthetic for; pneumonia secondary to aspiration of vomitus; live birth.

COMMENT

The Committee voted this case a preventable death. It was felt that there was a definitely poor choice of agents, which combined to produce anything but a desirable anesthetic effect upon the patient. Apparently no effort was made to ascertain the time and/or quantity of food last ingested. Although no definite chronologic sequence of events was stated, it was also felt that there was delay in the bronchoscopic procedure, and effort to establish an adequate airway.

CASE NO. 12

This patient was a 34 year old Negro, Para III, who died four minutes postpartum. In her past history she had had a spinal fusion for spondylitis (tuberculous) in 1946, and a thoractomy the same year. Her first two pregnancies were uneventful and delivery at term was uncomplicated; the children were now 10 and 12 years old. The last pregnancy was uneventful, and her prenatal care was believed adequate with 10 visits to her physician; her serologic test for syphilis was negative. When the gestation was near term, labor began spontaneously 24 hours following rupture of her membranes.

She was admitted to the hospital during the initial stages of labor and apparently progressed normally up to the time she was ready for delivery. Her medication consisted of nembutal® gr. 3, and demerol® 100 mg. At 12 o'clock midnight, when delivery was imminent, open drop ether was administered to the patient by a registered nurse in the usual manner; delivery was accomplished by low forceps over a right medio-lateral episiotomy, assisted by fundal pressure. The fetus was delivered alive at 12:16 a. m., and

the patient vomited and aspirated. At once the attending physician cleared the air passages, and noted that respirations had ceased. Artificial respiration, mouth-to-mouth breathing and stimulant drugs were all employed, with intracardiac adrenalin,[®] to no avail. Obviously the patient was dead at 12:20 a. m. Autopsy permission was obtained.

Pathological diagnosis: Status post anesthesia; aspirated food contents in bronchi; chronic bilateral fibrous pleuritis, healed right apex, cavity left apex; cold abscess left lumbar area, retroperitoneal; fatty changes of liver.

COMMENT

Again the Committee felt there was a poor choice in the anesthetic agent, and probably there was some error in its administration although details are lacking. No note was made of an attempt to ascertain the time and quantity of food last ingested. The case was voted a preventable death.

CASE NO. 92

This patient was a 19 year old Negro, Para III, who died 1½ hours postpartum. Her past history revealed an old anemia, but was not remarkable otherwise. Little is known concerning her first two pregnancies but it is believed they were delivered at term without complication. The patient had no prenatal care during her last pregnancy; serology was not obtained. She was admitted 12:20 p. m. at term, in active labor, and members of the hospital staff conducted a physical examination upon her; findings were within normal limits, except for a hemoglobin of 7.5 Gm. The patient was typed and two units of blood ordered. The cervix was dilated 4 cm, vertex presenting at plus 1 station, contractions every 3 to 4 minutes.

Labor was uneventful, and 40 minutes later (1:00 p. m.) she was given demerol[®] 100 mg. and seconal[®] 100 mg. Three and a half hours later the patient was given a saddle block, 5mg. pontocaine[®] in the sitting position; she was maintained in this position for 30 seconds, then placed in semi-Fowler's position. About two minutes later, there was hypotension (blood pressure 70/40), and oxygen was started at once. Ephedrine 50 mg. was administered intravenously, and 1,000 cc. 5 per cent dextrose in distilled water was given intravenously. Soon the blood pressure was 80 systolic. Delivery of a living female, 7 pounds, 5 ounces, was accomplished by low forceps at 3:56 p. m., with manual removal of the placenta shortly thereafter.

At 4:00 p. m. the blood pressure was 80 systolic; whole blood was administered. Respiratory difficulty began at 4:02 p. m., with the last respiration at 4:07 p. m. Artificial respiration was begun, followed by bag breathing at 4:20 p. m. using the anesthesia machine. At 4:23 p. m. the chest was opened, and cardiac massage begun. The heart was found dilated and quiet. Intracardiac adrenalin[®] was administered, followed by calcium lactate, and mechanical stimulation. The patient was pronounced dead at 5:26 p. m. There was no autopsy.

Cause of death: Cardiac arrest and shock, after spinal anesthesia; anemia (hemoglobin 7.5 Gm.); low forceps delivery; manual delivery of the placenta.

COMMENT

The Committee reviewed the facts available in this case and voted it a preventable death. Although there is no schedule concerning the

level of anesthesia obtained, the agent was believed to have ascended to a high level, or it might have entered the circulation through a small vessel during its administration. Little is known of the patient's general condition, except that her anemia was discovered upon admission to the hospital; if blood was available sooner, it should have been administered earlier. However, the Committee could not justify the patient's lack of prenatal care.

COMMENT OF CONSULTANT

The following comment of a consultant, who is a specialist in anesthesiology, was given at the request of the Committee.

The three cases outlined are examples of preventable deaths due to anesthesia complications. Before discussing each in detail, it seems pertinent to remark that death is a high price to pay for a few minutes of pain relief. Death due to anesthesia is almost always preventable. Whenever any anesthetic is administered, certain complications must be anticipated; one must be prepared and technically capable of dealing with them. If adequate equipment and skilled individuals are not present, it would be better to use no anesthesia at all, or to use local anesthesia which, although less satisfactory, is far safer.

Case 10. Pentothal[®] is not a good anesthetic agent for a delivery. Regurgitation, aspiration, and laryngospasm, as well as respiratory depression, may occur. When used, pentothal[®] should be given in doses of 1 or 2 cc. at a time, not 6 cc. as was done here. The description of an abundance of frothy liquid makes one think of pulmonary edema, but the likelihood is that aspiration of gastric contents can account for all of the difficulty. After the trouble began, treatment was inadequate and resuscitation was delayed, so that chronic anoxia finally caused the death. When an acute respiratory emergency arises due to anesthesia, the anesthetist must be able to give adequate treatment immediately. Calling a consultant may be good for one's conscience, but it does the patient no good since it is usually too late.

Case 12. This again illustrates the hazard of using general anesthesia for a patient who has food in her stomach. In obstetrical patients, the aspiration of vomitus is the most frequent complication of general anesthesia. The registered nurse who gave the anesthetic was apparently not a trained nurse anesthetist, thus violating the State Medical Practice Act. The attending physician attempted to clear the air passages, but was unable to do so, as shown by the autopsy. Artificial respiration by pressure on the chest or by mouth-to-mouth breathing cannot be regarded as adequate resuscitation. Stimulant drugs are useless.

The proper treatment for both this and the previous case would have been immediate clear-

ing of the pharynx, trachea, and bronchi, followed by artificial respiration with positive pressure oxygen. Had this been done, both of the deaths would have been prevented.

Case 92. The dose and technique of this spinal anesthetic administration seem to have been satisfactory. The difficulties which developed seem much more likely to have been due to a high level of anesthesia than to intravascular injection. That the anesthetic level was not checked is a grave omission. Treatment of the hypotension was inadequate. Adequate treatment of the respiratory difficulty was delayed too long.

The time of cessation of heart action is not stated, but it seems likely that the cardiac massage was also begun too late. This death could have been prevented by proper support of the circulatory and respiratory systems.

Summary: The errors of omission and commission, which result in anesthetic deaths, are usually simple. If every anesthetic were regarded as a deadly danger (which it is) and some thought and attention were devoted to minimizing the hazard, the anesthetic death rate could be reduced to the vanishing point.

A New Concept of Tension Headache And Associated Muscle Spasm

Skeletal muscle spasm associated with tension headache affects the scalp, cervical muscles, and frequently the trapezius muscle. The spasm should be regarded as a secondary effect which results from an intrinsic muscle disturbance. This intrinsic irritation, accompanied in many cases by vasoconstriction, results in pain and tenderness and, in some cases, muscle contraction. Cervical and scalp muscle spasm, per se, do not produce headache. The actual factor which triggers the pain mechanism is unknown, but is supposedly due to release of stress substances controlled by the hypothalamus.—Bernard D. Judovich, M. D., Philadelphia: *Pennsylvania M. J.*, 59:901, August, 1956.

Psychological Factors In Eczema

Many of the children who have easily eczematized skins are also generally "highly strung" and nervous . . . [This combination] may well lead to psychological stress but it is becoming increasingly recognized that such stress plays an important causative role . . . In an infant the frustration and unhappiness, when not handled and fed with the gentle care of a mother in harmony with her husband and surroundings, may play an important part in the disease. . . Some [cases] have cleared dramatically when the child has been sent away to relatives or school; some when the family have been rehoused and others when the mother's general health has been improved.—R. P. Warin: *Practitioner*, 175: 502, May, 1956.

Franklin County Pelvic Cancer Delay Committee Report

By JOHN H. HOLZAEPFEL, M. D.

Columbus, Ohio, Chairman

The Franklin County Pelvic Cancer Delay Committee met at the Columbus Health Center on September 19, 1956, at 12 noon. Two cases were presented.

Case 31: A 38 year old white female entered the hospital in September, with bleeding since April. No pain or discharge. Her family physician advised hospitalization and biopsy at date of first consultation. Pelvic examination revealed a small erosion on the cervix and some vulva condylomata. A biopsy was done with the diagnosis of leukoplakia of the cervix with request for more extensive biopsy. The second hospital admission was delayed until the following January, for surgery. At operation the cervix was dilated and a total hysterectomy and bilateral salpingectomy and left oophorectomy were done. The pathological diagnosis was squamous cell carcinoma of the cervix, early invasion, proliferative endometrium and chronic pelvic inflammatory disease. Patient received eight external therapy treatments totaling 2200 R. Papanicolaou smears at three month intervals have been negative except 13 months later in February when atypism was recorded. Recent papanicolaou smear in July was negative.

Comments: DR. JOHN H. HOLZAEPFEL: Patient delay of six months. Physician delay of five months.

DR. BEN JACOBY: There should have been a second biopsy prior to surgical treatment. The patient had neither complete irradiation nor complete surgery.

DR. FRANCIS GALLAGHER: Surgery done was inadequate; a right oophorectomy should have been included along with radical lymphadenectomy.

Case 32: Patient is 39 years old. She had a heavy odorous discharge for approximately one year prior to surgery; associated with this was occasional gushing of blood with large clots. She saw her family physician who gave her an examination and a "cancer test" in October. This was followed by some "desiccation treatments" and some pills and shots. Dissatisfied at the results, a friend referred her to another physician the following July. She was admitted to hospital where a sub-total hysterectomy was done for degenerating fibroids. The cervix was found to contain squamous cell carcinoma with no apparent metastases. On August 4th she received radium needle therapy and recent examination revealed good immediate results.

Comments: DR. HOLZAEPFEL: Nine months delay on the part of physician.

DR. WILLIAM MERRYMAN: No preliminary biopsy at the time of surgery.

DR. FRANKLIN HUGENBERGER: A sub-total hysterectomy was done for uterine fibroids without the knowledge of the cervical pathology.

Erythema Nodosum

Beta-hemolytic streptococcus skin tests may even precipitate new crops of erythema nodosum.—Cutting B. Favour, M. D., Palo Alto: *California Med.*, 85:207, October, 1956.

Introduction to Use of the Ophthalmoscope

WILLIAM H. HAVENER, M.D.

SUCCESSFUL ophthalmoscopic examination requires cooperation from the patient. He must hold his eyes still. This is facilitated by pointing out a distant object at which you wish him to look (or pretend to look if your head interferes). If he is seated and you are standing, the optional direction of gaze is about 20° up and temporal. A darkened room is necessary for proper examination. Dilatation of the pupil with 10 per cent neo-synephrine® greatly simplifies the examination. Glasses need not be worn by examiner or patient unless a high degree of astigmatism is present.

The beginner will find it easiest to start with the ophthalmoscope lens set at zero. He should approach to within a foot of the eye and sight through the ophthalmoscope aperture. (The right hand and right eye are used to examine the patient's right eye; left hand and eye for patient's left.) When the light is directed into the patient's eye, his pupil will glow a uniform red. This is the "red reflex" and is present in all normal eyes. Always keeping the red reflex in sight, approach the patient's eye until your forehead practically touches his.

Knowledge that you are looking at an eye only one inch away causes instinctive convergence and accommodation which are fatiguing and interfere with proper focusing. One should pretend he is looking through the patient's head at some far distant landscape. Both eyes should be kept open (by examiner and patient). Focusing is done by turning the lens wheel with your forefinger. Red (minus) numbers focus farther away; black (plus) numbers focus nearer. A prominent detail such as the disc or a large vessel should be brought into sharp focus. The best starting point is the disc, which may be found by following the vessel bifurcation, just as following down the branches of a tree will lead to the trunk. By this time you will have noted extremely annoying dazzling light reflections from the corneal surface. These may be avoided by moving slightly to one side or the other.

EXAMINATION

A definite routine should be followed in examination of the fundus, including:

1. Optic disc

This is the most conspicuous feature of the fundus, and these details should be noted:

(a) *Size*. Normal discs appear of a uniform size, which is readily recognized with a little experience. High myopic refractive errors magnify the disc; hyperopic errors minify it (e.g. after cataract extraction the disc looks very small).

Submitted May 14, 1956.

The Author

● Dr. Havener, Columbus, is on the attending staff at University Hospital, and Acting Chairman, Department of Ophthalmology, The Ohio State University College of Medicine.

Fundus distances are conveniently estimated in terms of disc diameters (DD). Thus, a lesion twice the size of the disc and situated in the upper right fundus may be described as being "2 DD in size, and 3 DD away from the disc at 1:00." The disc is approximately 1.5 mm. in diameter. All fundus details appear magnified 20x.

(b) *Shape*. The disc is normally round or vertically oval. Gross irregularities in shape and size should not be interpreted as being part of the disc, but are ordinarily adjacent pathology.

(c) *Color*. The healthy disc is a creamy pink color. This is due to a rich capillary network, the larger vessels of which are normally just visible. The center of the disc may be greyish if a deep physiologic cup exposes the lamina cribrosa. Infants have very grey discs which may easily be mistaken as being atrophic.

(d) *Physiologic depression*. Most discs have a small pit just temporal of center. This may be quite large, but never extends completely to the scleral edge. It may be deep enough to permit a clear view of the fine fenestrations of the lamina cribrosa. The abbreviation for physiologic depression is P.D.; for lamina cribrosa, L.C.

(e) *Margins*. Ordinarily the disc outline is more or less irregular, frequently with scattered pigment margins. It is possible to focus clearly on these irregular edges, indicating absence of edema or inflammation. Dense pigment deposits are often situated about the disc margin. Occasionally a greyish crescent of sclera is visible immediately adjacent to the disc.

2. Vessels

The central retinal artery and vein appear in the depths of the disc. Bifurcations are variable, and may occur deep in the disc, or not until the vessel reaches the retina. Four groups of vessels usually exist—superior temporal, inferior temporal, superior nasal, and inferior nasal. Each large vessel should in turn be carefully observed along its whole length from disc to periphery.

(a) Arteries are about one-fourth narrower than veins. (Absolute size varies with the number of branches, and it is easily understood that if two veins drain an area fed by one artery, the

artery will be the largest vessel.) A narrow band of light, the arterial light reflex, is seen to be reflected from the center of an artery. Arteries and veins may cross and entwine each other in any fashion, but normal arteries do not indent or displace veins.

(b) Veins are darker in color than arteries and do not have a prominent light reflex. At the disc extremity of a vein there is usually visible a slight pulsation (spontaneous venous pulsation) synchronous with the arterial pulse. This is due to the forcing of venous blood out of the eye with each arterial systole. External pressure on the globe with a finger during ophthalmoscopic examination will produce venous collapse or pulsation (only at the disc end of the vein) in all normal eyes.

3. Macula.

This is an area about 1 DD in size, situated 2 DD temporal to the disc. It is avascular, not even capillaries being present in its center which is nourished by the choroid. The minute glistening spot of reflected light seen in the center of the macula represents a pinpoint depression, the fovea centralis. Fine pigment granularity is normally seen in the macula, as well as in the periphery of the retina, which is not a homogeneous membrane.

If difficulty is encountered in finding the macula, instruct the patient to look directly at the ophthalmoscope light. This will place the macula in the center of your field of vision.

4. Periphery.

Although the area adjacent to the disc may be seen by aiming the ophthalmoscope beam in different directions, it is necessary to enlist the patient's aid to see the far periphery. Ask him to look up as you direct the ophthalmoscope up, left as you look left, right and right, down and down, and thereby scan the whole periphery. Various types of fundi exist normally.

(a) Tessellated fundi are those which are fairly darkly pigmented except for prominent, criss-crossing, linear, light orange streaks which represent choroidal vessels.

(b) Albinoid fundi are quite light in color, showing clearly the reddish choroidal vessels lying on the grey-white scleral background.

(c) Negroid fundi are uniformly quite dark.

(d) Most fundi are fairly uniform in coloration, and of a finely granular texture, with occasionally visible choroidal vessels. The peripheral retina is usually lighter than the central portion.

Light reflexes are glistening, movable reflections from folds in the smooth retinal surface. They are much more prominent in young individuals, characteristically parallel the vessels, and often encircle the macula and sometimes the disc.

Upon completion of the fundus examination, the more anterior portion of the eye may be

examined by turning to higher plus (black) lenses. In sequence, this will focus upon the posterior vitreous, anterior vitreous, and lens, which appear perfectly transparent and empty in the normal eye. Usually a +15 or +20 lens will be needed to see the iris and cornea from this close distance. About fourfold magnification of the iris results.

Proficiency in ophthalmoscopy is gained only through practice. It should be your custom to examine the eyes of every patient. This soon will lead to a considerable degree of skill in the use of your ophthalmoscope.

The Emotional Aspects Of Malignancy

Consideration for the patient's feeling is nowhere more important than it is in the care of the terminal patient. Here there is an even greater demand to understand the patient's emotional needs and the physician's own emotional reactions. The patient now has great need for a doctor who will give him emotional support and who will be dependable—a person who will be the patient's own doctor, someone whom he needs desperately to invest with superhuman powers, while all the while he realizes intellectually that very little is being done.

All this tremendous need for support puts a severe strain on the physician, and as he sees the patient getting worse and realizes his therapeutic helplessness in the face of terminal carcinoma, he may find it very disturbing to continue to treat the patient. The reaction on the part of the doctor may be expressed as a discontinuation of therapy, or a subtle change in the relationship on such logical grounds as not having time for the patient, or not wishing to take his money for a visit which can do no good. But the patient will never understand this; to him any alteration in the doctor's attitude toward him means rejection, and at such a crucial time in his life it is indeed a bitter pill to swallow.—Alexander S. Vujan, M. D., Pittsburgh: *Pennsylvania M. J.*, 59:479, April, 1956.

Pulmonary Function Test

The one additional laboratory examination which has been shown to have an extremely high correlation with the clinical severity, progress, or improvement of the patient with chronic pulmonary disease is the determination of the difference of the minute volume during quiet respiration when breathing air and breathing 100 per cent oxygen. Bickerman and Barach have reported an excellent correlation of the decrease and increase of this difference in pulmonary ventilation with improvement or increase in severity of symptoms, respectively, in pulmonary emphysema.—Gustav J. Beck, M. D., New York City, discussant of paper read by Howard G. Dayman, M. D., Buffalo: *New York State J. Med.*, 56:2813, September 15, 1956.

Near-Fatal Case of Intoxication with Meprobamate Treated with Electro-Stimulation And Levarterenol

ADAM G. ALLEN, M.D., and A. V. BLACK, M.D.

SINCE the use of a new tranquilizing agent (meprobamate) has been hailed as a safe method of treatment, with no reported cases of severe toxicity, it seems important to emphasize that care should be given in the use of this agent, and over-dosage treated vigorously.

Previously reported cases following ingestion of large doses (up to 40 grams) over a 24 hour period have been unattended by more serious sequelae than prolonged sleep with no depression of the cardiovascular or respiratory systems.

The case here reported developed both respiratory and vasomotor collapse with cessation of respiration and the absence of palpable pulse and blood pressure. Prompt intravenous administration of levarterenol bitartrate with cerebral electronic stimulation prompted uneventful recovery.

CASE REPORT

A 57 year old white woman was seen about two hours after ingestion of thirty to forty 400 milligram tablets of meprobamate and at this time there was complete loss of deep reflexes, fixed dilated pupils, and slight obstruction of the airway due to pharyngeal relaxation. Blood pressure, pulse and color were all normal.

The patient was treated with stomach lavage, administration of caffeine sodiobenzoate, metrazol,[®] oxygen—with no perceptible effect.

The blood pressure dropped progressively to about 70 systolic, plateaued for about two hours, then, seven hours after ingestion of the drug, the patient suddenly became pulseless, the blood pressure was unobtainable and respiration ceased.

Levarterenol bitartrate was immediately administered by vein, and cerebral electro-stimulation applied. The electro-stimulation was applied bitemporally by means of the Med-Craft Electronic Transient Therapy Unit, which produces a pulsating direct current of a stimulating type. Treatment was applied intermittently for three hours using variable frequency of 5 to 10 pulsations per second and variable intensity of 2 to 20 milliamperes.

For the first two hours, each time stimulation was stopped there was immediate collapse of the blood pressure and depression of respiration which was promptly restored on resumption of the stimulation. After three hours these func-

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tions were maintained without further treatment except the drugs as previously noted.

The patient regained consciousness about 15 hours after onset, all drugs were stopped and thereafter her course was uneventful so far as signs of intoxication were concerned.

The psychiatric aspects of the case will be reported later.

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Therapeutic Trial with INH in Cases Of Coccidioidomycosis

Since coccidioidal granulomas are histologically indistinguishable from tuberculous granulomas, a long course of isonicotinic acid hydrazide therapy was tried experimentally in three cases of coccidioidomycosis, with good results. In two cases the disease was far advanced and prognosis poor before INH therapy was begun. In one case the disease was mild and symptoms abated after a short course of small doses of INH. It recurred when INH therapy was discontinued, and again resolved when larger doses of INH were given over a longer period.

INH seemed to have an effect on appetite also, although the patients were taking B-complex vitamins both before and during INH treatment. The three patients ill with coccidioidomycosis averaged a weight gain of four and a half pounds a month during the period of INH therapy. Six well persons who were underweight and lacked appetite were given INH without other drugs, and they then had an increase in appetite and in weight.—Gerald A. Fostvedt, M. D., et al., *California Med.*, 85:167, 1956.

Submitted April 23, 1956.

Meprobamate Toxicity—Report of a Case

MYRTLE COLLINS-DINEEN, M. D.

MEPROBAMATE (equanil® or miltown®) is being widely used as a tranquilizer. One of its principal uses is in neurotic and depressed patients. It is to be expected that some of these patients will take large amounts in suicidal attempts.

Selling¹ reported that two in his series of 187 patients treated with meprobamate took large amounts. One took 20 grams of meprobamate in 24 hours, was markedly sleepy with a pulse of 40 when seen. She was treated with hot coffee and awoke after sleeping 10 hours. The second patient took 100 tablets (40 grams) within 24 hours and "suffered no serious adverse effects." Further details were not mentioned.

Borrus² emphasizes the sedative, hypnotic and soporific qualities of meprobamate but does not mention instances of massive doses.

CASE REPORT

A 53 year old white female professor was discovered in coma nine hours after taking approximately 14 grams (thirty-five 400 mg. tablets) of meprobamate in a single dose.

For a number of years she had been under psychiatric care. She had been hospitalized and treated with electric shock during the past year. Seven months before this episode she had resumed her teaching duties. She was seen by a psychiatrist the afternoon preceding this suicidal attempt.

When seen at home, the patient was comatose and cyanotic, with stertorous respirations. The skin was dry and warm. The pupils were pinpoint and did not react to light. The lips and mouth were dry. Her blood pressure was 115/70 mm. Hg, pulse 80 per minute, respirations 20. She did not respond to painful stimuli. Biceps and knee jerks were absent. Caffeine sodium benzoate 0.5 Gm. was given intramuscularly and she was transferred to a hospital.

On admission her blood pressure had fallen to 90/70 mm. Hg, pulse was 100. Respiratory rate was 28 and temperature was 101°F, per rectum. There was some increase in cyanosis and knee jerks were faintly present. Oxygen was immediately administered. A Foley catheter was put in place.

Admission laboratory studies were: hemoglobin, 14 Gm. per 100 cc. (91 per cent); packed corpuscular volume 43 mm.; white blood count, 19,200 per cubic millimeter; differential white count: neutrophils 94 per cent, lymphocytes 5 per cent, monocytes 1 per cent. Blood bilirubin direct was 0.2 mg. per 100 ml. and total 0.6 mg. The blood urea was 5 mg. per 100 ml. Bromsulphalein® showed less than 5 per cent of dye remaining after 30 minutes. Catherized urine was acid with a trace of albumin and no sugar. There were 2 to 4 white blood cells per high power field and 1 to 2 fine granular casts per low power field.

Since both the drug taken and the time of administration were a matter of conjecture at this time, gastric lavage was attempted but abandoned

The Author

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when a period of apnea resulted. An airway was inserted and oxygen therapy resumed.

Procaine penicillin, 300,000 units intramuscularly, picROTOXIN 3 mg., benzedrine® sulfate 120 mg. (20 mg. intravenously every 15 to 30 minutes) in 5 per cent glucose in water were given in the next three hours.

Three hours after admission, during suction of pharynx, the patient moved her extremities. Pupillary reflex was weakly present. Blood pressure was 96/60 mm. Hg. Pulse was 120. Respiratory rate was 20. Knee jerks were present. An additional 120 mg. of intravenous benzedrine® sulfate were given in the next seven hours. Twelve hours after admission she was moving both arms and legs. Spontaneous movements of the eye lids and the gag reflex gradually returned. Twenty-four hours after admission she responded to her name and recognized relatives. Her blood pressure was 120/70 mm. Hg.; pulse 88; respiratory rate 20, and temperature 101°(R). Her color remained normal out of oxygen. She was walking about 36 hours after admission.

Because of the marked depression and suicidal desires, the patient was transferred to a psychiatric hospital on the third day.

COMMENT

The foregoing case report indicates that deep coma with cyanosis and hypotension can be caused by 14 grams of meprobamate when taken as one dose. After seeing the cyanosis and coma from 14 grams, it is difficult to believe this patient could have survived a dose of 40 grams. Both of Selling's¹ reported cases took their larger doses over a period of 24 hours which accounts for the milder effects. He reports no cyanosis and does not mention coma.

Since meprobamate has an antagonistic action to pentylenetetrazole, Borrus² suggests the use of the latter in meprobamate poisoning. This was considered in treating this patient but the response to intravenous benzedrine® sulfate and oxygen was satisfactory and it was decided that the increased hazards of pentylenetetrazol need not be undertaken.

As with other soporific and hypnotic drugs, the physician should avoid prescribing large quantities of meprobamate. Although it has not been reported, it seems likely that larger doses (i. e. over 20 grams) could be lethal. The pos-

Submitted August 16, 1956.

sibility of accidental poisoning of children must also be borne in mind.

In addition to the use of large doses in suicidal attempts, other complications of the use of meprobamate can be mentioned here. This seems especially relevant because these have been minimized. In his series of 187 cases, Selling¹ noted two cases of urticaria, one patient of which had fever, and one case of angioneurotic edema. While Borrus² reported no serious or toxic manifestations from meprobamate, he mentions drowsiness in one-half of the patients and possibly headache in a few cases. The Council of Pharmacy and Chemistry³ presents meprobamate with essentially the same statements adding that the drowsiness is evidence of its somnifacient action rather than a side effect.

Lemere⁴ originally stated that meprobamate is not habit forming but further clinical experience revealed that this is not always so. Lemere⁵ found withdrawal symptoms of nervousness and "jitters" above the premedication level after discontinuing meprobamate. Six patients formerly addicted to alcohol or barbiturates refused to continue meprobamate because they felt they were becoming "addicted."

One of Lemere's patients convulsed 12 hours after withdrawal of the drug. There was no history of previous convulsions and it brought to mind convulsions seen after alcohol or barbiturate withdrawal. This, as he writes, suggests a physiological dependence. He had six other patients who persisted in taking excessive amounts of the drug. Five of these were alcoholics who were abstemious at the time. Two showed dysarthria, euphoria, and generalized incoordination. The other four merely slept all day, to which the families objected. Further meprobamate was refused these six. A psychological craving is created in some patients, according to Lemere's⁵ experience.

While meprobamate is relatively nontoxic, the following must be guarded against: 1. Allergic reactions; 2. Excessive self-medication to satisfy psychological dependency; 3. Suicidal attempts.

SUMMARY

A case of meprobamate overdosage in a suicidal attempt is reported. The resulting cyanosis and coma of 24 hours' duration in spite of active therapy indicate that this is not an innocuous drug. A review of the literature reveals other complications of meprobamate therapy, namely: allergic phenomena, psychological dependency and possibly physiological dependency.

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What Hormone Therapy Cannot Accomplish

Several observations made during long-term cortisone therapy of rheumatoid arthritis suggest that the basic disease process does not seem to be influenced by hormone therapy in doses which are practical for long-term administration. First, new joints can become involved by the disease while the patient is receiving apparently adequate doses of steroid.

Second is the appearance of subcutaneous nodules during therapy. These lesions consist of necrotizing granulomas, which are the pathologic lesions characteristic of rheumatoid arthritis; these lesions have been found in synovial membrane, in fibrous tissue filling defects in cartilage and bone of involved joints, in the pericardium, myocardium, aorta, lungs, pleura, dura, skeletal muscles, and in the walls of arteries.

During early studies of the effect of steroids it was felt that subcutaneous nodules resolved more rapidly or stopped increasing during steroid therapy. Further observation has revealed that these nodules can persist unchanged or, more significantly, can appear during steroid therapy, indicating that a basic pathological process is continuing. This observation has been made in patients receiving long-term cortisone therapy and more recently during prednisone therapy.

Finally, destruction of cartilage and bone in involved joints has been observed to progress in patients clinically doing well on hormone therapy. These observations were first made in patients treated with cortisone, and the same observations have now been made in a series of patients with rheumatoid arthritis being treated with prednisone and prednisolone.

The occurrence of these phenomena indicates that the basic disease process is continuing despite therapy. A cooperative British study found no significant difference between aspirin- and cortisone-treated patients with early rheumatoid arthritis after a period of two years of therapy, lending further support to the concept that hormone therapy does not significantly alter the basic disease process.—Alfred Jay Bollet, M. D., Detroit: *J. Michigan M. Soc.*, 55:278, March, 1956.

Eczema of Hands Due to Cleansers

The criteria for diagnosis of eczema of the hands due to soap and allied cleansers, according to Jordan and Osborne are: (1) Hands are completely free of eczema or improved during warm months. (2) They improve during vacations, illnesses or other lapses in routine when irritants are avoided. (3) Attacks of eczema are precipitated by frequent usage of these irritants. (4) Eruptions are vesicular and confined to the hands, usually the dorsal aspect, with involvement of one or more fingers. Palms are seldom involved.—James W. Burks, Jr., M. D., New Orleans: *J. Oklahoma State M. A.*, 48:208, 1955.

Overdosage with Meprobamate—Presentation of Case

E. CREDE Hiestand, M. D.

INTRODUCTION of meprobamate (2-methyl-2-n-propyl-1, 3-propanediol dicarbamate) to clinical medicine has placed a new tool in the hands of physicians for treatment of disorders associated with physical and emotional tension. Since the drug is of greatest use among emotionally disturbed patients, instances of deliberate overdosage with suicidal intent may be expected.

CASE REPORT

A 40 year old white female was admitted to the emergency room of Allegheny General Hospital, Pittsburgh, Pa., about one hour after having attempted suicide by ingestion of 90 to 95 tablets (36 to 38 Gm.) of meprobamate.* The drug had been prescribed to relieve her "nervous tension." Although she had never previously attempted to take her own life, she had threatened to do so several times.

A sister stated that the patient had been under severe emotional strain because of social pressures and family misfortunes. Her husband and at least three relatives had met violent deaths in accidents. She smoked about one package of cigarettes a day and was reputedly a heavy drinker. The family history was negative for any inheritable disease. The patient's medical history was noncontributory. The systemic review was essentially negative.

Physical examination presented a well developed, well nourished, comatose woman in no apparent distress. Blood pressure was 86/60 and pulse 132; respirations, regular and deep, were 24 per minute. Her pupils were contracted nearly to pinpoint position with very little reaction to light; the eyes were roving and uncoordinated. The ears were normal, mouth edentulous, and neck supple. No enlarged nodes were palpated.

The chest was clear and the heart was regular with good tones and no murmurs. A tachycardia was present. Abdominal examination was negative. The extremities were normal. On neurological examination the patient failed to respond to any sensory stimulus. The entire body was completely relaxed and flaccid. Muscular tone was completely absent, and no reflexes could be obtained. Further neurological study was of no value because of the patient's nonreactive condition.

Because relatively little is known concerning the effects of such a massive dose of meprobamate, the reported low toxicity of the compound and the apparent absence of distress, it was decided to manage the patient conservatively, with vigilance for evidence of deterioration in vital functions, and treatment of any complications that might develop. No attempt was made to counteract the drug aside from administration of 80 mg. amphetamine sulfate parenterally in divided doses over a period of three hours. Since meprobamate and amphetamine act primarily on different areas, amphetamine sulfate was discontinued.

Submitted August 6, 1956.

*Meprobamate is produced commercially under the trade name equanil® by Wyeth Laboratories, and miltown® by Wallace Laboratories.

The Author

● Dr. Hiestand, Old Fort, Ohio, now in private practice, recently completed internship (1955-1956) at Allegheny General Hospital, Pittsburgh, Pa.

The dentures were removed and an oral airway inserted, which the patient tolerated well.

One hour after admission the blood pressure dropped to 78/50 and an intravenous infusion of an aqueous solution containing 1 cc. of phenylephrine hydrochloride in 1000 cc. of 5 per cent dextrose was started. Even with a flow of about 70 to 80 drops per minute, the pressure remained between 84 and 90 mm. Hg systolic. Pulse ranged from 110 to 132 per minute. Oxygen was administered and mucus aspirated.

Four to six hours after admission the pupils enlarged to approximately midposition and became reactive to light, but otherwise the condition remained unchanged. About 18 hours after admission the patient began to resist aspiration slightly and to move the extremities in response to stimulation. At 24 hours she would no longer tolerate the oral airway, and at 30 hours she first responded to vocal stimuli by opening her eyes.

Urine obtained during the first 24 hours from an indwelling catheter had a peculiar, pungent, fruity odor similar to the odor of meprobamate. This subsided after the first day. The patient then gradually awakened over the next 36 hours. She slept for long intervals but aroused at times for a few minutes and then lapsed back into sleep.

By the time the patient had been in the hospital 72 hours she was awake, fairly alert, willing to talk and seemingly completely recovered, with no complaint of headache or other after-effects. There was a questionable transient tinnitus for a short period. Her blood pressure had gradually risen, and became stabilized at about 110 mm. Hg systolic; her pulse progressively decreased to a mean of 78 per minute. The patient stated that she remembered nothing of her arrival or stay in the hospital until she awakened, and that she had not dreamed except for a short time during awakening.

Urinary output remained normal. Laboratory studies included a blood count and urinalysis; serology, blood sugar, nonprotein nitrogen and blood urea nitrogen determinations; cephalin flocculation, thymol turbidity and serum bilirubin tests; and total protein and A/G ratio determinations. All findings were normal except for hemoglobin, which was 11 Gm.; and a positive serologic test for syphilis, for which appropriate measures were instituted. The patient was discharged with no apparent residual effects from overdosage with the drug.

COMMENT

Meprobamate, which is chemically related to mephesisin, was originally studied as a muscle relaxant. The relaxant properties and inter-

neuronal blocking action were described by Berger's group.¹ The same author described changes in the electroencephalographic pattern suggesting that meprobamate also exerts a tranquilizing effect on the central nervous system, particularly the thalamic area, with little or no depressant action on vital functions.^{2,3}

Selling⁴ and Borrus⁵ reported successful clinical use of meprobamate in certain psychiatric disorders, with almost no toxicity. Several minor allergic reactions have been reported, but none which were not easily controlled by either withdrawing the drug or concurrent antihistamine medication.

Relatively little is recorded in the literature concerning the effect of massive doses of meprobamate in human beings. Selling⁴ cites two patients who took an overdose of the drug. One ingested approximately 20 Gm. over a period of 24 hours and the other approximately 40 Gm. (100 tablets). Neither patient suffered any serious adverse effects, which suggests that the toxicity of the drug is remarkably low.

In the case described, no serious complications arose from ingestion of 36 to 38 Gm. meprobamate. Aside from the fact that the patient was flaccid and in a deep sleep, the only abnormality was a moderate tachycardia and hypotension. This may have been the result of direct action of the drug on the circulatory control mechanism of the medulla; or the complete loss of muscle tonus may have interfered with the ability of the vascular system to maintain normal tone, with consequent drop in pressure.

Because of the experimental evidence that meprobamate will inhibit electroconvulsive and pentylenetetrazole-induced seizures,² Borrus⁵ has suggested that pentylenetetrazole may be indicated as an antagonist in suicidal attempts using excessive amounts of meprobamate.

Although the case reported is only a single instance, it tends to confirm previous reports concerning the low toxicity of the drug and suggests that general supportive measures suffice for treatment of overdosage. The fact that respiration and circulatory functions are so little affected, even after ingestion of massive doses, is an indication that the drug possesses a wide margin of safety not afforded by conventional sedatives and hypnotics.

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The Story Behind the Word

Some Interesting Origins of Medical Terms

Gamboge—This yellow gum resin which is used as a drastic purge was so named because it was obtained from the "gamboge" tree or *Garcinia morella* which grows in Gambodia or Cambodia in Asia.

Genetics—This branch of biology which deals with the phenomenon of heredity and variation and was so named in about 1906 by William Bateson, an American physician. The term is derived from the Latin word "genus" meaning race or kind.

Garlic—This strongly flavored plant of the lily family which is commonly used as a seasoning, derives its name from the Anglo-Saxon word "garleac." It was so named because of its spear-shaped or pointed leaves and the term is composed of the Anglo-Saxon word "gar," or spear, plus "leac" or leek meaning a pot-herb.

Gene—Coming from the Greek words "genes-thai and gignesthai," meaning "to be produced" and the Latin word "genus" meaning "race or kind," this term was adopted in the nineteenth century to designate any hereditary factor. These factors are present in the chromosomes and carry the hereditary characteristics.

Genital—Pertaining to the organs of generation or reproduction, or the act of begetting, this term came into English via the French from the Latin word "genitalis" meaning "serving to beget" and "gigno"—"I beget."

Giddy—In ancient times when a person was roused, excited, or excessively merry it was believed that he was possessed by the "gods or demons," and so the Anglo-Saxon word "gydig" literally meant the "God-held" man. From this came the later Anglo-Saxon word "giddian" meaning "to be merry." Our word "giddy" descended to us from these terms and by extension has come to mean a confused sensation of swimming or whirling in the head.

Ginglymus—Descriptively designating a hinge joint, such as the joint of the elbow and lower jaw, this term is derived from the Greek word "gingglumos" meaning "a hinge."

Gluteus—This is a New-Latin word which is used to designate one of the large muscles of the buttocks. It is derived from the ancient Greek word "gloutos" which was used in the Iliad to designate the hip and by Herodotus for the rump or buttocks.

Gnat—Coming from the Anglo-Saxon word "gnaet" and applied to any one of various dipterous insects such as the mosquitos, blackflies, biting midges and sand-flies, this word is said to be imitative of the humming "gna'gna'gnaet" sound made by these insects while flying about before attacking.

—HARRY WAIN, M. D., Mansfield, Ohio.

Evaluation of a Proprietary Milk Formula on the Growth and Development of Infants*

HARRY D. PASACHOFF, M.D.; MICHAEL G. MULINOS, M.D.;
DAVID STEINBERG, M.D., and ALBERT SHERWYN, M.D.

MUCH discussion has accompanied the use of human milk substitutes in infant feeding. Even though cow's milk forms the basis of such diets, modified and supplemented to resemble human milk, the one and only criterion of effective nutritional value must remain the response of infants actually fed such formulas. Attempts at imitation of the physical and chemical properties of human milk sometimes fail to stress the importance of nutritional adequacy when demonstrating other and allegedly desirable qualities.^{1,8}

Recently, Barbero et al.¹ gave data which show that certain milk preparations were better able to maintain intestinal pH and bacterial flora similar to those from human milk, than were others, including evaporated milk. However, they gave no evidence that these differences in stool composition were reflected in the nutritional value of the formulas in question as compared to human milk feeding.

DIETARY COMPARISONS

Pasachoff et al.² put to the test the implications inherent in Barbero's conclusions, i. e., that stool composition similar to that from human milk reflects a nutritionally superior formula. These investigators found no correlation between the hydrogen ion concentration of the stool, or of its bacterial population, and the growth and general health of the infant, in response to several artificial diets, as well as breast feeding. It was concluded, "... that the effectiveness of an infant's diet must be measured by its ability to maintain a steady and sufficient gain in growth . . ." Because the criterion of growth adequacy in this study had been based only on the first month of life, it was deemed necessary to extend the time to the full six months as suggested by the Council of Foods and Nutrition of the American Medical Association.³

The advantages of an evaporated cow's milk formula have been appreciated for many years.⁴ Convenience, purity, and consistent quality, together with necessary complementation render many of the proprietary infant foods now available quite acceptable to all concerned. However, it is axiomatic that the actual nutritional

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Submitted December 19, 1955.

*This work was supported by a grant-in-aid from The Baker Laboratories, Inc., Cleveland, Ohio.

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value of any one food preparation must first be demonstrated by tests on infants under rigid controls before it may be accepted for routine use. Some recent experiences may be cited during which convulsive disorders⁵ or megaloblastic anemia⁶ developed when changes made in the formulas were not checked under controlled conditions prior to wider distribution.

NUTRITIONAL ADEQUACY

A series of observations was instituted to extend and improve upon the one month's data on growth and development already reported upon in another connection,² using Baker's Modified Milk as a basis for the diet. This formula is made from Grade A milk (U. S. Public Health Service Code) which has a bacterial content prior to sterilization much lower than that of milk commonly used for evaporated milk or other infant food formulas. The absence of large numbers of bacterial cells tends to reduce the danger of allergic sensitization to the bacteria, and to lessen allergic manifestations should bacterial sensitivity be present.

In order to obtain better tolerance and more efficient fat utilization, the butterfat has been replaced by coconut oil, corn oil, and destearinated beef fat. This composition provides adequate amounts of the essential fatty acids. In accordance with the recommendations of the Food and Nutrition Board, Baker's Modified Milk provides 3.7 grams of protein per kilogram of body weight per day. In addition, sufficient dextrose, maltose, lactose, and dextrans are supplied to raise the carbohydrate to the breast milk level of 7 per cent. The use of several sugars reduces the

likelihood of digestive disturbances resulting from incomplete assimilation of the carbohydrates. Iron and vitamins have been added so that there was supplementation only with vitamin C.**

EXPERIMENTAL

The plan of procedure followed the recommendations set down by the American Medical Association.⁸ It aimed to establish proof that Baker's Modified Milk would sustain adequate growth and development during the first six months of life when milk forms the most important part of the diet. The 35 infants used in this study were born at the Morrisania City Hospital. They were unselected except that they should be term babies without obvious physical defects, and that the mothers were willing to cooperate in the study. The offer of a free milk supply was helpful and insured prompt revisits. The cases were scattered through a year (April 1953 to May 1954) in order to include seasonal variations in the presence or lack of respiratory, gastrointestinal upsets, and seasonal variations in growth. Because the study was conducted in a city hospital, the infants belonged to families of relatively low socioeconomic status, thus putting a more than usual strain on the nutritional qualities of the dietary.

SIX MONTHS' DATA

Of the 35 infants started, the data on 10 are not included in the analysis because they did not embrace the whole six months. Soon after birth each infant underwent a thorough physical examination, with measurements of body weight and length; head circumference; roentgenograms of the epiphyses of the long bones, and a complete hemogram. Each infant was then started on the milk formula while still in the hospital. At the time of discharge a supply of milk was given to the mother sufficient to last until the next visit, usually a two weeks' supply.

The physical examination, bodily measurements and the hemogram were repeated every two weeks. A second roentgenogram of the long bone structure was taken at the end of the six months of observation. At each visit there was taken a history of digestive disturbances, incidence of colds and other infections, as well as the satisfaction of the mother with baby's progress. The infants were allowed no supplementary vitamins except ascorbic acid, of which each received 50 mg. per day. At 2 months of age, cereal was added to the milk diet; at 3 months, vegetables were added, fruits being allowed at 4 months of age. No iron supplement nor eggs or meat were allowed for the duration of the study.

RESULTS†

Roentgenograms of the long bones of both

upper and lower extremities were taken during the first week of life. Twenty-two infants had normal bone structure and a normal bone age. In two cases there were missing ossification centers indicating some delay in bone age. Another case was reported as showing unusually marked density of all the long bones, not including hands or feet. All three abnormalities had disappeared at the six month roentgenogram.

While roentgenogram in one case taken at birth showed a normal bony architecture, those at 6 months revealed dense bands at the lower ends of the diaphysis of both the radius and ulna, but the bones of the lower extremities were normal. This infant showed no clinical evidence of rickets. Caffey⁷ considers such bands of increased density as normal, occurring in many otherwise healthy infants and children.

At 6 months of age, roentgenograms of the long bones revealed normal bone architecture and the absence of any evidence of rickets or other abnormalities. The hemograms showed no evidence of iron deficiency.

The infants accepted the milk formula readily and did well on the half-and-half dilution with water. In one infant there was noted colic and excessive flatulence during the first two and one-half months. This infant was evidently hypertonic, but in addition there was evidence of overfeeding as gauged by the rapid gain in weight during this time. In none of the other infants was there colic or other disturbances. There was no vomiting or excessive regurgitation.

UNTOWARD SYMPTOMS

There were five instances of diarrhea lasting two to five days, all of which were accompanied by an upper respiratory infection of a mild nature. In addition we encountered six instances of rhinitis without diarrhea, but at no time did these infants fail to gain in weight. The incidence of colds was no greater than in other subjects during the season of observation.

One of the babies developed a diaper rash intermittently throughout the six months of observation. There was evidence that poor home hygiene was the responsible factor. In six other instances a slight erythema of the perineal region was noted on single occasions during the six month period of observation. This was in contrast to the findings of Pratt and Read,⁸ who ascribe an increased incidence of perianal dermatitis in evaporated milk fed infants to the higher pH of the stool. Therefore there must be other factors than pH of the stool in the causation of perianal dermatitis, since we did not observe it in this series. Eczema or other allergy mani-

**At about the middle of this study, sufficient vitamin C was added to the prepared milk to provide 50 mg. per quart of diluted formula. This eliminates the necessity of adding it as a supplement.

†Because of space consideration three summary tables have been omitted here. The tables, which show in detail the physical measurements and hemograms during the six months of observation, are included in the authors' reprints and may be obtained by writing to the authors.

festations suggestive of sensitivity to the milk formula was not observed in this series of cases.

SUMMARY

Thirty-five newborn infants at a city hospital ward were fed a formula of Baker's Modified Milk, diluted by half with water. Of these, 25 were observed for the full six month period necessary to assay nutritional adequacy as defined by the American Medical Association.

The infants were observed, weighed and measured every two weeks, at which time complete hemograms were also taken. Roentgenograms taken within the first week after birth and repeated at 6 months of age revealed normal bone structure. The growth and development of all 25 infants, without exception, was well within normal limits. The nutritional status of every infant was excellent throughout the period of observation. The formula was accepted readily without gastrointestinal or other disturbances. The incidence of perianal dermatitis was minimal. The formula appears to be nutritionally complete, since normal development occurred without supplementation of iron or vitamins, other than vitamin C (now no longer necessary).

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Skin Testing for Reducing Penicillin Reactions

In order to reduce the number of reactions, Swift has advocated testing for penicillin sensitivity with scratch and intracutaneous tests on all suspected individuals receiving the drug. However, other authors have pointed out that patients found to be sensitive to penicillin by skin tests may fail to give a subsequent systemic reaction while individuals not reacting to the tests may develop a systemic reaction. Long has advised not to give penicillin if there have been previous penicillin reactions or allergic illnesses.

While such inquiries, discriminations, and skin tests will reduce the amount of penicillin given and the total number of reactions, the patient may still develop an anaphylactic reaction. Such a patient may have a negative past history and fallible skin tests.—Phillip L. Nudelman, M. D., Portland, Oregon: *Northwest Medicine*, 55:1074, October, 1956.

Development of Conscience In a Child

A child's conscience is not inherited but is developed, especially during the first six years of life, through imitation in great detail of the total behavior of parents. This imitation embraces the conscious and unconscious operations of the parents. To an equal extent, conscience develops from the parents' conscious and unconscious image of the child and from their concepts and hopes and fears for the child. . .

Misguided through popular talks and psychiatric literature, many parents . . . are afraid to set limits with the child for fear of repressing him and making him neurotic. . . .

A child must be made to feel guilt about doing antisocial things, and if the anger resulting from the parental prohibition is allowed legitimate verbal expression, no neurosis develops and a good conscience develops about forbidden behavior.—A. M. Johnson: *Pediatrics*, 17:934, June, 1956.

Cutaneous Irritants Encountered By Various Occupational Groups

Bakers and housewives: cinnamon, flour conditioners, lemon, spices, sugar.

Barbers and beauty operators: rubber gloves, hair tonics, soaps, shampoo materials, permanent wave solutions, hair dyes.

Button factory workers: ivory and horn dust, brass, nickel, gold, silver.

Candy makers: oil of cassia, peppermint, orange, lemon, anise, cloves, vanilla, citric acid, cashew nuts, pineapple, citrus fruits.

Clerks: glue, carbon paper, desk pads, polishers.

Dairy workers: alkaline cleansers.

Diesel mechanics and operators: radiator fluid containing sodium bichromate.

Dry cleaners: solvents, soaps and detergents.

Farmers and gardeners: plants, woods, artificial fertilizers, insecticides, fungicides.

Florists: many plants, fertilizers, insecticides.

Food preservation workers: juices, essential oils, food dyes, preservatives, insecticides, vinegar.

Garage workers: solvents, tetraethyl, anti-freezes.

Grocery employees: insecticides, dyes of labels, dry ice.

Janitors: polishes, soaps.

Laundry workers: soaps, starch, bleaches.

Lumber workers: foreign and native woods.

Medical and dental workers: local anesthetics, formalin, rubber gloves (artificial and natural rubber), mercurials, phenol, iodine.

Pastry cooks: essential oils of citrus fruits, vanilla, cashew nuts, cinnamon.

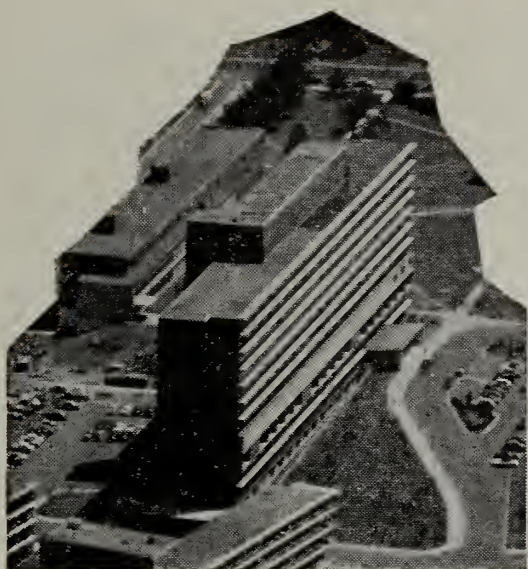
Sporting goods makers and users: lead, rubber, nickel, chrome, leather and leather dyes.

Undertakers: embalming fluids.

Waterproofers: resin, sodium carbonate, chrome, glue, potassium bichromate, turpentine.

—Leonard F. Weber, M. D., Chicago:

J. Iowa M. Soc., 46:492, September, 1956.



A Case Record

From The University Hospital,
Columbus, Ohio

Edited Under the Auspices of the Ohio Society of Pathologists

Philip Wasserman, M. D., President

Presented by E. H. Ellison, M. D., and Emmerich von Haam, M. D.

Edited by Dr. von Haam

DR. EMMERICH VON HAAM: The case we are presenting today does not involve diagnostic problems so much as it involves problems of therapy. Gallbladder surgery is done yearly on several thousand patients in many hospitals and the risks to the patient arising from this type of operation are considered small by the expert. For this reason gallbladder surgery is often recommended on a selective basis even though the patients may not be troubled by severe symptoms but may just show the presence of gallstones in a routine x-ray examination. Today's case illustrates some of the difficulties a patient may get into after so-called "routine" gallbladder surgery.

CASE PRESENTATION

A 54 year old white woman entered University Hospital for the first time because of severe anemia. A cholecystectomy had been performed seven years before for unknown reasons and four days after the operation she became jaundiced and was again operated upon. A drain was left in for about six months, through which bile, up to 1 pint per day, was discharged. She remained jaundiced.

One year after the first operation the newly formed bile duct was allegedly anastomosed with the small intestine. She continued to have once or twice a month intermittent attacks of jaundice accompanied by feelings of weakness and chills. Four days before admission she again felt very weak, had chills but no fever. During the past year she had developed a severe anemia which resisted all therapy. Her last red cell count before admission was 1.77 million.

PHYSICAL EXAMINATION

The blood pressure was 140/80, the pulse 92, respirations 20, temperature 98°F. The patient appeared well nourished. Her skin was deeply

bronzed, her sclerae were jaundiced. The heart sounds were clear. The abdomen showed a well healed right paramedian scar and old drain sites. The liver was down 5 fingerbreadths and felt nodular. The spleen was barely palpable.

LABORATORY DATA

The admission red blood cell count was 2.19 million, the hemoglobin 4.5 Gm.; the leukocytes numbered 5,750. The findings on bone marrow examination were felt to be consistent with chronic blood loss. Urinalysis revealed a dark brown urine with a specific gravity of 1.018, protein negative. Reaction to the direct van den Bergh test was 4.3 mg., indirect 5.6 mg.; thymol turbidity 20 units; prothrombin time 94.5 per cent; cephalin flocculation negative. The urobilinogen content of the feces was 136 mg. Tests for occult blood in the stool were positive. The blood cholesterol was 325 mg. with 36 per cent esters. Alkaline phosphatase was 132 units. Serological tests for syphilis were negative.

ROENTGENOGRAPHIC EXAMINATION

X-ray examination revealed a normal esophagus, one suspicious varix of the stomach, no definite ulcer crater but a small duodenal diverticulum, and some air in the biliary tree. Visualization of the tree by contrast dyes was impossible.

HOSPITAL COURSE

The patient was placed on a low-fat diet. Her fever rose on several occasions to 104.5°F. A liver biopsy was interpreted as compatible with chronic cholangitis. The red blood cells rose to 3.7 million following multiple blood transfusions. On the seventeenth hospital day an exploratory laparotomy was performed. A tube was inserted into one bile duct. During the operation bile started to gush from an invisible area and later severe bleeding was encountered which was

Submitted September 27, 1956.

thought to come from the portal vein. The patient lost about 3,500 cc. of blood.

After surgery the blood pressure dropped to 70/0. There was profuse bile drainage along the Penrose drain following operation. The urine output for the first night after surgery was 8 cc. Potassium was up to 6 mEq., blood urea nitrogen was 33 mg. The patient remained oliguric and the blood urea nitrogen rose to 164 mg., the potassium to 7.6 mEq., and the CO₂ combining power fell to 20 volumes.

On the seventh postoperative day the patient developed convulsions, and after heparinization she was connected with an artificial kidney at 2:15 p.m. on that day. At 4 p.m. the blood pressure fell to zero, the patient went into Cheyne-Stokes respirations and she expired at 12:35 a.m. the following day.

CLINICAL DISCUSSION

DR. E. H. ELLISON: Dr. von Haam was right when he introduced this subject as a problem which is not too infrequent. As a matter of fact, we see all too many of them. This patient probably had not had any severe trouble until the time she was operated upon. We cannot ascertain from the histories that are on the various charts why she came to surgery except for the fact that she had gallstones. This in itself may be enough indication for surgery, but I cannot be certain as to the symptoms that she had previous to her cholecystectomy. She was described as having been in good health.

It is also difficult to ascertain just what happened to this patient at her operation, but it seems obvious that her common duct must have been either tied or severed. I do not want to sound too critical, because injury to the common duct can happen to anyone and it has happened to a lot of good surgeons. The important thing is to recognize it when it happens because that is the best, in fact the only, time that you can repair it satisfactorily.

The patient became jaundiced four days after her cholecystectomy. This usually means that there has been a direct injury to the common duct, either a ligation or a division of the duct. Tearing of the duct does not necessarily happen only in the short, fat patient but can quite easily occur in thin individuals where the surgeon is so amazed how easily his cholecystectomy seems to be proceeding that he is unaware of the fact that he has pulled the duct up as he dissects the gallbladder loose and tears or splits the common duct.

Another thing that happens to him is that he gets a hemorrhage into the area from some anomalous arterial supply. The whole wound fills with blood and in desperation a clamp is put deep in the wound where the bleeding is coming from and is often placed around the duct. You cannot put blind clamps into this area without asking for trouble. These are the two

major causes of injury to the ductal system.

Strictures do not occur immediately but about two months after operation, and the gradual narrowing of the duct makes for a slowly progressive jaundice. According to the story, she was then reoperated upon but we do not know how long after her initial injury this took place. Usually the surgeon likes to postpone going back for fear the reaction around the injured duct is so great that he cannot identify the structures to let him repair it.

At the time of reoperation a tube was supposedly placed in her duct. They probably found the proximal end of her injured ductal system, put a catheter into it and brought it to the outside. Apparently it drained bile very nicely for about six months. They left the tube in place until a fistula formed to the outside. Then the plan was to go back and dissect out this tract of fibrous tissue which had developed around the tube and anastomose it to the duodenum.

DUCT REPAIR

This is one of the first methods that was used to repair injuries to the ductal system and I have never seen one that worked quite well. They work for a while and then they form a stricture and obstruct. But this was what was done and apparently the patient improved somewhat, at least she was not draining bile to the outside any more and she was not severely jaundiced. Apparently she was getting some bile through for a while.

As so often happens when you implant these fibrous ducts into the duodenum, bile pigments accumulate in this tract until it is finally completely blocked again. As the pressure is built up in the biliary tract the block may be removed, but then a second complication starts to develop, namely, an ascending infection along this tract since the patient has no longer a sphincter here and intestinal contents can contaminate the biliary tree.

Our patient gives a typical history of such a situation, where she would be perfectly well except for a mild jaundice for about a month. Then she would have anorexia for a day or two followed by marked chills, fever, and anorexia. She could not eat and she would be sick for about a week. She always received antibiotics and she usually recovered after five to seven days. This repeated itself time and time again. Probably after each time the patient was a little more deeply jaundiced than before, because as this infection proceeds the bile ducts will fibrose and obliterate within the liver. So the ascending cholangitis finally turns into an obliterative cholangitis.

Her family physician finally sent her to our Hematology Service because the patient over the preceding two to three months, in addition to her other problems, developed a marked anemia.

Apparently up until this time anemia had not been a problem and it would be my guess that her family doctor, and probably rightly so, suspected hypersplenism. These patients can get into the same kind of troubles as patients with primary liver cirrhosis, and as a matter of fact sometimes the pathologist is hard pressed to differentiate the two unless he knows the history. Of course there may be other reasons for her anemia, because along with her biliary cirrhosis she might easily have formed varices from portal hypertension. These folks develop increased portal pressure just like any patient with cirrhosis.

BONE MARROW

The Hematology Service felt on the basis of bone marrow studies that she did not represent a case of hypersplenism but rather an anemia due to blood loss. Because they were faced with this problem of bleeding, they looked in vain for a bleeding source. The esophagus was quite negative and the stomach findings were inconclusive. Sometimes an acute bleeding ulcer may develop if the biliary tract is blocked for a long time and the alkaline juices from the liver can no longer get into the gastrointestinal tract, and I have seen patients with massive hemorrhage from large duodenal ulcers on the basis of total biliary obstruction. Again the x-ray examination was negative and the patient also had normal prothrombin values and there was no evidence of increased hemolysis.

Her pulse was a little high for a deeply jaundiced patient and this would make one a little suspicious that she was in chronic shock. Most of her liver function tests looked pretty good with the exception of the cholesterol esters. It has been our experience that patients with low esters always represent a poor surgical risk. Her alkaline phosphatase was still markedly elevated, indicating that our patient still had sufficient liver tissue left to produce alkaline phosphatase. Her total proteins were normal when she came in and she had almost a normal A:G ratio. So apparently she looked a pretty good risk as far as the liver function was concerned except for the low cholesterol esters.

She received 3 units of packed cells and one of whole blood. It would be my hunch that she needed a lot more than this because her initial red count and hemoglobin were markedly depleted. The patient was put on a low fat diet.

In the hospital she was still having her attacks of cholangitis. The surgical consultant was rather hesitant to recommend anything for the patient. She had been this way for seven years. He did feel that he would like a liver biopsy prior to operation, and it proved to be compatible with chronic cholangitis. There apparently were ducts present which were still open although they were not dilated. Some of her other blood findings suggested hypersplenism, but in many

of these patients one cannot differentiate blood loss from true hypersplenism or a hemolytic anemia along with a very mild jaundice. The surgeon wanted the patient to go back home and think about it. It was near Christmas time, but she saw some hope of getting back to normal living again and was anxious to take the risk. And so, perhaps a little against the surgeon's judgment, surgery was decided upon.

After going through old scar and many very vascular adhesions the surgeon succeeded in freeing a loop of jejunum from the hilus of the liver and finally a gush of thick green bile was encountered which appeared to escape from a thickened duct high at the hilar region. The portal vessels appeared uncommonly distended and after more dissection a massive hemorrhage occurred and the patient lost approximately 3,700 cc. of blood from the portal vein. After the bleeding was under control it was felt that nothing further could be done at this time; a drain was inserted and the patient was closed up. They hoped that the appearance of bile meant that the obstruction was overcome and that once again the patient would not be jaundiced.

HEPATORENAL SYNDROME?

Immediately after operation the blood pressure dropped as low as 70 over 0. This is important because jaundiced patients who have one episode of hypotension often develop the so-called "hepatorenal syndrome." There was profuse bile drainage along the Penrose drain following operation, which probably made everybody feel pretty happy. The urine output for the first night after surgery was only 8 cc., but the patient did not remain totally anuric.

During the next three days the blood urea nitrogen rose to 153 and the CO₂ went to 20 and the serum potassium rose to 7.5 mEq. The Levin tube was removed on the fourth day, but the patient vomited the whole night and it was replaced. Soon after this period of marked vomiting the patient went into shock and it became difficult to maintain her blood pressure. Her blood proteins dropped to 4.08 Gm. and she showed a persistent acidosis, as so often these patients with deep jaundice do.

Acidosis in the jaundiced patient is very difficult to manage. You can't give them sodium lactate as you would like to because the liver cannot take care of the lactate, and so they turned to sodium bicarbonate, which did not help the patient very much. The blood calcium fell to 6 mg. and she had her first convulsion. At this time apparently everybody had given up and so they put her on the artificial kidney with a diagnosis of uremia and impending death through uremia and hyperpotassemia. They gave her calcium intravenously, which controlled her convulsions. Her blood urea nitrogen fell very promptly to 33, the CO₂ went back to normal and her other electrolytes were quite good. But need-

less to say, it is a very traumatic procedure for the patient to have the whole blood volume replaced time and time again. Soon after she came off the artificial kidney she developed Cheyne-Stokes respiration and died.

So altogether I wonder several things: First of all, it seems a shame that it had to be seven years after her initial operation that she finally was operated upon again. I wonder if perhaps we surgeons should decide not to operate upon patients who have been partially obstructed for such a long time, as very few of them survive the hazards of additional surgery. I suppose we feel that we should give them one more chance, and it is usually the last one.

The other thing that comes to mind is that I think perhaps postoperatively she had a period of acute gastric dilatation which may have precipitated her shock and started her on her downhill course. Along with this she had evidence of rather severe bleeding from her gastrointestinal tract, which may have been a consequence of her portal hypertension. She was at times disoriented and I am sure this probably was caused by an elevated blood ammonia which was not recognized. Finally, I am not too sure why she was put on the artificial kidney because on the day she went on, the urine output was 550 cc. with a normal specific gravity, a fall in blood urea nitrogen and a normal potassium.

BILIARY CIRRHOSIS

My final diagnosis is that of severe biliary cirrhosis with secondary obliterative cholangitis. I think there is a good possibility that she had portal hypertension along with her biliary cirrhosis and that bleeding varices in her stomach could explain her anemia and her positive guaiac stools. Along with her marked splenomegaly and portal hypertension I wonder if she did not have some elements of hypersplenism, particularly a hemolytic anemia, which contributed to her jaundice.

I am quite impressed with the radiological detection of air in her bile ducts, and I am sure if the surgeon had seen that he would not have operated. I think she probably initially was worse off than anybody thought, and I am sure she should have had a little preoperative build-up with blood and albumin.

Following surgery she probably developed a bile peritonitis, since she did have an opening into the biliary tree. She certainly had an acute hypoproteinemia and was malnourished postoperatively, with a marked hypocalcemia. Whether or not she had a lower nephron nephrosis, I don't know. I think it must have been very mild. Finally as her terminal event she developed complications in her chest. Perhaps she had an atelectasis or a pneumonia after she was on the artificial kidney.

The patient's main problem was chronic biliary

disease the treatment of which had been delayed too long.

CLINICAL DIAGNOSIS

1. Injury to the common bile duct.
2. Biliary cirrhosis.
3. Status post recent reexploration.
4. Bile peritonitis.
5. Gastrointestinal hemorrhage from gastric varices.
6. Acute gastric dilatation (postoperative).
7. Shock.
8. Pulmonary atelectasis with early bronchopneumonia.

PATHOLOGIC DIAGNOSIS

1. Postoperative stenosis of common bile duct.
2. Chronic cholangitis with early biliary cirrhosis.
3. Pulmonary atelectasis with early bronchopneumonia.
4. Esophageal varicosities with gastrointestinal hemorrhage.
5. Congestive splenomegaly.
6. Cholemic nephrosis.

PATHOLOGIC DISCUSSION

DR. VON HAAM: Upon opening the body we found about 150 cc. of bile-stained fluid in her peritoneal cavity together with marked congestion of the intestinal serosa and extensive recent and old adhesions in the right upper quadrant. The heart was normal in size and the pericardium showed the petechial hemorrhage which we observe so often in jaundiced patients. The lungs showed marked atelectasis of the right lower lobe and numerous confluent areas of hemorrhagic consolidation throughout both lungs. The spleen weighed 610 grams and appeared firm and congested.

The liver weighed 2,000 grams and had the green hobnail-like appearance that one encounters in a moderately advanced case of cirrhosis. The anastomosed portion of the newly created common duct was dissected and found to be dilated and filled with gray mucus and small stones. It ended shortly above the anastomosis in a stricture through which a probe could not be passed. Beyond the stricture the short remaining portion of the common duct and its two main branches were markedly dilated and a fistula at their junction led into a cavity bordered by the liver and the hepatoduodenal ligament. The cavity was filled with bile.

The wall of the portal vein appeared hemorrhagic and traumatized although no actual tear could be demonstrated. The mucosa of the esophagus was eroded and inflamed and had been bleeding recently. No stomach ulcer could be found, but the stomach contained much coffee-ground-like material. The small intestines were

very edematous and the contents were hemorrhagic. Her kidneys were slightly enlarged and soft and showed a pattern which we interpreted grossly as that of cholemic nephrosis.

MICROSCOPIC EXAMINATION

Sections through the lungs showed an early confluent bronchopneumonia with much hemorrhagic edema and numerous bacterial colonies. Apparently the patient had no more leukocytes left to combat this infection and died from terminal septicemia against which the body offered no resistance. Sections through the spleen showed the typical fibroadenia of a spleen in portal hypertension but no evidence of reticulum-cell hyperplasia so essential for the diagnosis of hypersplenism. We also did not find any evidence of increased hemolysis or leukocyte retention.

Sections through the esophagus showed moderately developed varicose veins and much superficial ulceration with recent hemorrhage. This was probably caused by the traumatic effect of the stomach tube and no doubt was the actual cause for her repeated although not excessive bouts of gastrointestinal hemorrhage. The blood vessels also showed occasionally a necrotizing angiitis probably caused by her terminal septicemia.

Sections through the liver showed a chronic cholangitis with biliary cirrhosis and some fatty metamorphosis. The liver parenchyma was not too badly damaged although there was some evidence of bile necrosis. Foci of more recent inflammation interchanged with foci of scar tissue indicative of a combined and progressive intrahepatic disease, as Dr. Ellison suggested. Sections through the structure identified as common bile duct showed a wall composed of thick masses of fibrous tissue without any smooth muscle or mucosa. It showed little chronic inflammation. The pancreas was normal.

Sections through the intestine showed a necrotizing patchy enterocolitis as we observe sometimes in patients who are treated with certain types of antibiotics. Overgrowth of the resistant flora, usually staphylococci, will cause this condition, which may be severely toxic and even fatal. Sections through the kidneys showed a very mild cholemic nephrosis with a little interstitial edema and a few bile casts. I do not think that the patient died from renal failure.

In summary, I agree wholeheartedly with Dr. Ellison that the patient probably could have waited longer and that at this point her third operation was not absolutely necessary. I think the patient died eventually from her staphylococcal enterocolitis and bronchopneumonia which developed during postoperative shock. I also think, however, that if the patient had not been operated upon she would have developed progressive liver destruction and that her esophageal

varices would have been the next and probably fatal complication.

GENERAL DISCUSSION

MEDICAL STUDENT: How do you explain the presence of gallstones?

DR. ELLISON: Ordinarily gallstones do not reform after cholecystectomy, but on the other hand they have been found in the hepatic and common bile ducts of patients without gallbladder.

DR. VON HAAM: I believe that this patient probably had stomach trouble and probably had gallstones. She may not have been jaundiced and they probably discovered the gallstones by x-ray. So they took out her gallbladder and tied or cut the common duct. They reoperated and anastomosed the newly formed duct below the stricture to the duodenum, which caused her seven years of intermittent cholangitis with increasing biliary obstruction. Then we tried to repair the patient, broke through the stenosis but also produced a severe hemorrhage. It is very hard to repair anything that has gone this far in scar formation.

DR. ELLISON: I think these are the most difficult cases for a surgeon to do.

DR. VON HAAM: Yes, just look at that fibrous tissue. You can't rebuild any channel in this area. You only can make another opening and it would close up again in a short time.

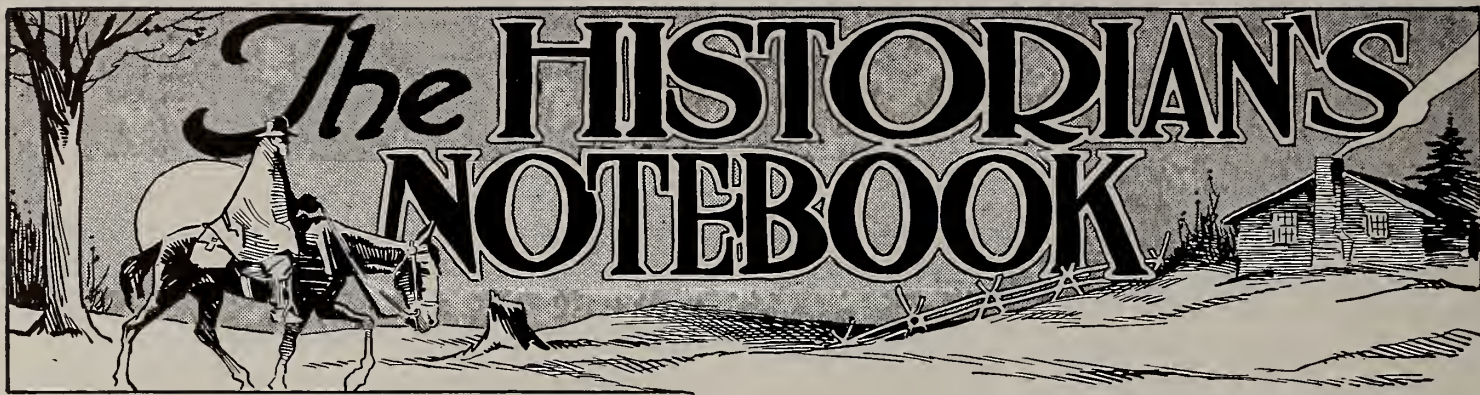
DR. ELLISON: The other thing you have to contend with is the great technical difficulty produced by the large livers, which force you to work practically in the dark in these critical areas. I think this case demonstrates again that no gallbladder operation is without risk and should teach us to approach the decision for cholecystectomy with the great feeling of responsibility it deserves.

The First Decade of Atomic Medicine

The first decade of atomic medicine culminated in the Geneva Conference, an unprecedented scientific meeting where all the nations of the world pooled their knowledge of biomedical as well as atomic technology in the unclassified area. The contributions of the United States alone filled seven large volumes.

What is the essence of the progress made in these past 10 years?

Ionizing radiation, formerly confined to the laboratory, the hospital and the radiologist's office, has become of significance to the entire population of the globe. Mechanisms by which radiation affects living tissue have become much more clearly understood, and the problems of exposure to radiation have become more starkly outlined.—Shields Warren, M. D., Boston: *J. Florida M. A.*, 43:152, September, 1956.



A Chronological Review of Ohio's Enviably Medical Record

Part II—The Second Seventy-Five Years

LINDEN F. EDWARDS, Ph. D.

(Continued from November issue)

1914

DR. WALTER G. STERN, of Cleveland, devised a sterile electric engine for cutting bone in amputations and presented his three cardinal signs of fracture in or near joints (Kagan, *Am. Jewish Physicians of Note*, loc. cit., p. 254).

Dr. F. H. McMechan founded the *Quarterly Supplement of Anesthesia and Analgesia* of the *American Journal of Surgery*, the first regular periodical devoted to anesthesia (*Who Was Who*, 1943, p. 820).

Dr. Weston Price devised an automatic device for recording temperature, blood-pressure and respiration rate during operations (*Bull. Ohio State Dent. Soc.*, 7:168, 1933).

Dr. Samuel Iglauer suggested the use of electromagnets for the extraction of metallic bodies from the trachea and bronchi (Kagan, *Am. Jewish Physicians of Note*, loc. cit., p. 254).

The American Academy of Periodontia was organized in Cleveland (*Bull. Ohio State Dent. Soc.*, 8:37, 1934).

1915. The law for the regulation of the practice of nursing in Ohio was enacted by the Legislature (Rodabaugh, loc. cit., p. 344).

Drs. Elmer I. McKesson and Ira O. Denman, of Toledo, originated a technique and designed a chair for tonsillectomy under nitrous oxide and oxygen gas anesthesia (*Am. J. Surg.*, 29:181-185, 1915).

Dr. Dennis E. Jackson, of Cincinnati, introduced a soda-lime absorber for carbon dioxide to provide successful rebreathing in inhalation anesthesia (*J. Lab. & Clin. Med.*, 1:1-12, 1915).

Dr. Alfred Friedlander described the comple-

The Author

- Dr. Edwards, Columbus, is professor of anatomy, The Ohio State University College of Medicine.

ment deviation test for the early recognition of whooping cough (Kagan, *Jewish Medicine*, loc. cit., p. 318).

1916. The first school for anesthetic technicians in the United States was established at Lakewood Hospital, Cleveland, by Dr. G. W. Crile (McCarthy, K. C.: *Ohio State M. J.*, 45:585, 1949).

The first complete base hospital to be organized in this country during World War I was the Lakeside Hospital Unit and was the first to leave for overseas duty (Rodabaugh, loc. cit., p. 346).

1917. Drs. David Marine and O. P. Kimball, of Cleveland, were the first to furnish proof by animal experimentation that goiter can be prevented or controlled by the administration of iodine (*J. Lab. & Clin. Med.*, 3:40, 1917).

Dr. Homer Brown was elected an honorary member of the Association of Military Dental Surgeons in appreciation of his efforts to place Dentistry on an equal plane with Medicine in the Armed Forces (*Biographies of Prominent Dentists*, loc. cit.).

1918. Dr. Stanley R. Benedict, a native of Cincinnati, while teaching Biochemistry at Cornell University Medical College devised the

Submitted August 17, 1956.

chemical test for glycosuria (Pollack, H.: *Diabetes*, 2:420, 1953).

George H. Wilson, D.D.S., of Cleveland, is credited as furnishing the motivating force in the founding of the Academy of Denture Prosthetics (*J. Prosthetic Dent.*, 1:3-6, 1951).

1921. Dr. Edward Francis, a native Ohioan, while serving in the U. S. Public Health Department discovered a new disease which he called Tularemia (*Who's Important in Medicine*, 1945, p. 167).

The Columbus Cancer Clinic, which claims the distinction of being the first such clinic in the United States, was opened to the public (*Twenty-fifth Anniversary of the Columbus Cancer Clinic*, 1946, p. 10).

1922. Dr. F. H. McMechan founded *Current Researches in Anesthesia and Analgesia* (*Who Was Who*, 1943, p. 820).

The First Annual Congress of Anesthetists met in Columbus on Oct. 31st of this year (McCarthy, loc. cit., p. 585).

1924. Dr. Harry R. Trattner, of Cleveland, devised an instrument for recording ureteral peristalsis (Kagan, S. R.: *The Modern Medical World*, 1945, p. 118).

Dr. Claude S. Beck, of Cleveland, reported his surgical technique for the relief of mitral stenosis and of his invention of an instrument, the cardiovalvulotome, for the performance of the operation (*J. Exper. Med.*, 40:375, 1924).

1925. The Ohio State University College of Pharmacy announced the adoption of a four-year curriculum, the first pharmacy college in the United States to adopt this requirement (Christensen, B. V.: *Ohio State Arch. & Hist. Quart.*, 61:359, 1952).

Dr. Charles A. Doan, a native of Nelsonville, while serving on the staff of the Carnegie Institute of Washington, D. C. with Drs. Cunningham and Sabin discovered the relationship between the circulating monocyte and the epitheloid cell of the bacillus tubercle (Carnegie Inst. of Washington Publication No. 82, *Contributions to Embryology*, vol. 14, p. 125, 1925).

1926. Drs. B. S. Kline and A. M. Young, of Cleveland, announced the slide precipitation test for syphilis (*J. A. M. A.*, 86:928, 1926).

On May 20th of this year Drs. Culter, Levine and Beck of Cleveland were the first surgeons ever to operate on a human patient for the relief of mitral stenosis. (Bailey, C. P.: *Surgery of the Heart*. Philadelphia, Lea & Febiger Co., 1955, p. 16).

Harvey Cushing, M.D., published the first monograph ever to appear dealing with the classification of gliomatous tumors of the central nervous system (*A Bibliography of the Writings of Harvey Cushing*, 1939, p. 13).

Drs. Allen Graham and Elliott C. Cutler of

Cleveland were the first to demonstrate that toxic adenoma and exophthalmic goiter are not two distinct diseases as had been held up to that time, (*Ann. Surg.*, 84:497-508, Oct. 1926).

Dr. Samuel Iglauer devised an intubation method of injecting iodized oil in x-ray diagnosis of laryngeal, tracheal and bronchopulmonary conditions (Kagan, *Am. Jewish Physicians of Note*, p. 259).

Dr. Albert H. Freiberg, of Cincinnati, described Freiberg's disease—infraction of the second metatarsal bone (Kagan, *ibid.*, p. 260).

1927. Dr. E. I. McKesson announced the invention of an artificial larynx for patients to talk following laryngotomy (*J. A. M. A.*, 88:645, 1927).

Drs. J. M. Rogoff and G. N. Stewart, of Cleveland, were the first physicians ever to administer an adrenal cortical extract, which they termed "interrenalin," to a human patient with Addison's disease (*J.A.M.A.*, 92:1569-1571, May 11, 1929).

Drs. Alfred Friedlander and S. Brown devised a formula for determining heart size in relation to the diameters of the thorax (Kagan, *Jewish Contributions to Medicine in America*, 1934, p. 446).

Dr. J. F. Baldwin removed a gallbladder containing over 25,000 gall stones, the largest number ever reported up to that time (Baldwin, loc. cit., p. 52).

1928. Dr. Carl J. Wiggers, of Cleveland, reported his studies on the hemodynamics of valvular defects (*Bull. Med. Hist.*, 1928, p. 152).

Drs. Glasser, Portman and Seitz, of Cleveland, reported the development of a condenser dosimeter for measuring the amount of radiation to which a patient is exposed (*Am. J. Roentgenol. & Radium Therapy*, 20:505, 1928).

1929. Dr. E. I. McKesson introduced the Nargraf apparatus for recording automatically the percentage of oxygen and pressure of gases administered, respiratory rate and blood pressure during anesthesia (*J. Anesth. & Analg.*, 13:1, 1934).

The Bureau of Dental Hygiene was created in the Ohio State Health Department (*Bull. Ohio State Dent. Soc.*, 4:21, 1930).

1930. Dr. Maurice Levine, of Cincinnati, was the first to demonstrate brain (psychogalvanic) responses to painful stimuli under hypnosis (Kagan, *Am. Jewish Physicians of Note*, p. 263).

1931. Development of the Bolton-Broadbent cephalometric x-ray apparatus for studying facial growth was announced by Dr. Holly Broadbent, of Cleveland (*Angle Orthodontist*, 1:45, 1931).

1932. Dr. Maurice Levine in collaboration with Dr. H. G. Wolff presented the first physiologic proof of the presence of sensory nerves in the cerebral vessels, a fact of vital importance in the

mechanism of headache (*Arch. Neurol. & Psychiat.*, 28:140-150, 1932).

Dr. J. A. Toomey, of Cleveland, was the first to demonstrate on experimental animals a toxic factor in the stools and urine of poliomyelitis patients (*J. Prev. Med.*, 6:387, Sept. 1932).

Dr. Harry R. Trattner devised an apparatus for the graphic registration of spinal fluid pressure and of the function of the ureter with the use of an hydrophoragraph (Kagan, *The Modern Medical World*, 1945, p. 118).

1933. Dr. Frank Hartman and collaborators, of Columbus, isolated a lactation hormone, Cortilactin, of the adrenal cortex (*Proc. Soc. Exper. Biol. & Med.*, 30:783, 1933).

1934. Dr. Harry Goldblatt and co-workers, of Cleveland, furnished experimental proof that ischemia of the kidneys by compression of the renal arteries produces elevated blood pressure (*J. Exper. Med.*, 59:347, 1934).

1935. Dr. Claude S. Beck, of Cleveland, performed the first operation on a human patient for the relief of obstruction of the coronary arteries by implantation of the pectoralis major muscle onto the heart wall thus establishing a new blood supply (*Ann. Surg.*, 102:801, 1935).

Dr. Cecil Striker and co-workers, of Cincinnati, introduced trichlorethylene as a short, rapid inhalation anesthesia (*J. Anesth. & Analg.*, 14:68-71, 1935).

1937. Dr. Walter M. Simpson, of Dayton, had the distinction of serving as chairman of the First International Conference on Fever Therapy in New York City, Mar. 29-31. (*Fever Therapy, Abstracts and Discussions of Papers Presented at the First International Conference*, 1937).

1938. Dr. Tom D. Spies, of Cincinnati, and associates were among the pioneers, if not the first, to use nicotinic acid in the treatment of pellagra (*J.A.M.A.*, 110:622-627, Feb. 26, 1938).

1939. Dr. Frank Hartman and collaborators isolated a factor of the adrenal cortex concerned with sodium retention (*Science*, 89:209, 1939).

Drs. B. K. Wiseman and C. A. Doan, of Columbus, were the first to describe a granulopenic syndrome caused by excessive granulocyte phagocytosis by splenic clasmatoocytes (*J. Clin. Invest.*, 18:473, July, 1939).

1940. The Cleveland Health Museum, the first of its kind on the Western Continent, was opened to the public (Gebhard, Bruno: *Ciba Symposia*, 8:591, 1947).

Mass x-ray survey for tuberculosis was inaugurated by the Columbus Tuberculosis Society, the first in the country to use that method (*Columbus Citizen*, May 11, 1952).

Dr. Cecil Striker was elected the first president of the American Diabetes Association

(Kagan, *Am. Jewish Physicians of Note*, 1942, p. 203).

Drs. George T. Pack, a native Ohioan, and E. M. Livingston, of New York City, published a three volume treatise on the treatment of cancer and allied diseases, the first, most comprehensive text on the subject ever compiled (*Treatment of Cancer and Allied Diseases*, New York, N. Y., Paul B. Hoeber, Inc., 1940).

1941. Dr. Lowell Erf, of Columbus, was the first physician ever to administer radioactive isotopes to a human patient for the treatment of leukemia (*Health Center Jour. O.S.U.*, 6:8, 1956).

1942. Dr. George Y. Shinowara and collaborators, of Columbus, announced an improved test for bone cancer based on the determination of serum acid phosphatase activity (*J. Biol. Chem.*, 142:921-933, 1942).

1945. Dr. Tom D. Spies and associates were the first to report that folic acid induces a hemopoietic response in patients with anemia (Spies, T. D.: *Experiences with Folic Acid*, Chicago, Ill., Year Book Publishing Co., 1947, p. 15).

Dr. Hugh G. Beatty, of Columbus, performed plastic surgery on a 19-month old baby with an extra mouth, the first reported case of its kind in medical history (*Columbus Evening Dispatch*, Sept. 26, 1955).

1946. Dr. Fred A. Hitchcock and co-workers, of Columbus, were the first investigators to report the physiologic and pathologic effects of explosive decompression (*J. Aviation Med.*, 17:596, Dec. 1946).

The first course in dental hygiene in Ohio was inaugurated at the Ohio State University College of Dentistry (*Bull. College of Dentistry 1945-1946*, pp. 36-40).

1947. The first university course in the nation for the training of dental technologists was inaugurated in the College of Dentistry, The Ohio State University (Meckstroth, K. W.: *Ohio's Health Center*, 1953).

1948. Dr. Harry D. Spangenberg, Jr., of Columbus, reported an experimental study of the production of roentgenograms by means of x-ray radiation of teeth and their supporting structures with radioactive isotopes (*O.S.U. Engineering Experiment Station News*, 20:48-50, 1948).

Dr. William G. Myers, of Columbus, was the first to suggest the applicability of radioactive cobalt (Co^{60}) for radiation therapy in neoplasms (*Science*, 107:621, June 11, 1948). Dr. Allan C. Barnes, of Columbus, made the first application of Co^{60} in a patient with carcinoma of the cervix (Meckstroth, C. V.: *The Ohio State University Health Center Journal*, 4:37-41, July, 1954).

1949. Drs. J. R. Haserick and D. M. Bortz, of the Cleveland Clinic, and M. M. Hargraves, a

native Ohioan, of the Mayo Clinic, described the L. E. cell phenomenon as a reliable diagnostic test of lupus erythematosus (*The 1949 Year Book of Dermatology and Syphilology*, p. 189).

1951. Dr. William G. Myers and associates were the first to announce the implantation of radioactive cobalt (Co^{60}) in plastic tubing for interstitial radiation therapy (*Radiology*, 55:553-559, April, 1951).

Dr. Arthur G. James, of Columbus, made the first use of radioactive cobalt in inoperable cancer of the head and neck (*Cancer*, 4:1333-1337, 1951).

Dr. George Y. Shinowara announced a new concept of the coagulation mechanism involving a lipoprotein, which he named the thromboplastic cell component or TCC (*J. Lab. & Clin. Med.*, 38:11-22, 1951).

The Ohio State University College of Dentistry moved into new clinic quarters and enjoys the unique distinction of being the first dental college in the nation to adopt the individual office or cubical system and "family dentist" teaching plan (Robinson, H. B. G.: *J. Dent. Ed.*, 18:167-169, May, 1954).

1952. Dr. William G. Myers and associates were the first to report the implantation of radioactive gold (Au^{198}) in the form of gold seeds for gamma-ray cancer therapy (*Cancer Research*, 12:285, April, 1952).

1953. Dr. Pauline Rossel, of Columbus, founded and supported a colony home for retarded young men who are self-supporting, the first experiment of its kind in the United States (*The Columbus Citizen*, Dec. 12, 1954).

A brief summarization of the data presented in Parts I and II bring out three striking features. In the first place it is evident that many innovations in the formal training for the various health professions have been inaugurated in Ohio; secondly, the dentists of this state have been especially active in their professional organizations, journalism and colleges; and thirdly, the medical profession in Ohio has pioneered not only in numerous specialties but also in methods of treatment of diseases and in new surgical procedures. Finally, due credit should also be given to the many public spirited citizens of Ohio for their efforts in organizing such health organizations, as the Ohio Tuberculosis and Health Association and the Columbus Cancer Clinic, the firsts of their kind in the nation.

In conclusion it should be stated that Ohioans can point with pride not only to the fact that more glass, rubber, clay products, Liederkranz cheese and soap are produced in this state than in any other but also that the number of "Firsts" that have transpired in the health professions in Ohio constitutes an enviable record surpassed by few if any other states in the union.

BOOKS OF HISTORICAL INTEREST

Early American Science: Needs and Opportunities for Study, by Whitfield J. Bell, Jr., (\$1.25. *Institute of Early American History and Culture, Williamsburg, Virginia*). Mr. Bell, formerly Boyd Lee Spahr, Professor of American History at Dickinson College and now assistant editor of the papers of Benjamin Franklin, has prepared this survey and bibliography of early American Science as a guide to students of this period. It forms an excellent guide to background material for American Medical History.

Bellevue Is My Home, by Salvator R. Cutolo, M. D. (\$4.00. *Doubleday and Co., Inc., Garden City, N. Y.*). This story of one of the world's greatest hospitals has been developed from the tape recordings of the author Barbara Gleb, author of *The ABCs of Natural Childbirth*, and her husband Arthur Gleb, the well known critic of *The New York Times*. Dr. Cutolo has lived and worked in Bellevue for over 25 years. It is the story of a Hospital which began its work 40 years before the American revolution and has witnessed within its walls many "firsts" in modern medicine.

History of American Funeral Directing, by Robert W. Habenstein, Ph. D., and William M. Lamers, Ph. D. (\$5.00. *Bulfinch Printers Inc., Milwaukee 2, Wis.*). This is an attempt to tell in broad outlines the story of American Funeral Directing. Nevertheless as a background for this development of the past century, the authors give us a look at the long record of western civilization in an effort to give selective depth and meaning to funeral beliefs and practices of modern America.

Transylvania, Pioneer University of the West, by Walter W. Jennings. (\$4.00. *Pageant Press, Inc., 130 W. 42nd St., New York 36, N. Y.*) A distinguished professor of economics at the University of Kentucky has made this volume a notable contribution to the growing social history of the South. We students of medical history are naturally interested in the fact that Transylvania University had the first medical school West of the Alleghenies, and one of the fine libraries of the times. This library is still intact on the campus of the university. However, this is the story of the whole school. It tells of the clashes, feuds and rivalries as the school was maintained at different times by Baptists, Episcopalians, Presbyterians, and Methodists. Anyone going to Lexington can see the auditorium where Henry Clay, Jefferson Davis, and other distinguished southern gentlemen attended chapel in their student days.

FOLKLORE

Folklore of early Connecticut relates that biting the backbone of a blacksnake was considered a preventive for snakebite.

Looking Ahead —



It isn't too early to make Hotel Reservations Now for the 1957 ANNUAL MEETING of the OHIO STATE MEDICAL ASSOCIATION. The place is COLUMBUS: the dates, MAY 14, 15 and 16, 1957. Here is a list of leading downtown Columbus hotels and a hotel reservation blank for convenient mailing.

NAME AND LOCATION	SINGLE	DOUBLE	TWIN
NEIL HOUSE, 41 S. High St.	\$ 6.00-11.00	\$ 9.00-11.00	\$11.00-14.00
DESHLER-HILTON HOTEL, W. Broad & N. High	\$ 5.00-13.50	\$11.00-18.50	\$11.00-18.50
FORT HAYES HOTEL, 31 W. Spring St.		\$ 9.00 up	\$ 9.00 up
SENECA HOTEL, 361 E. Broad St.	\$ 4.00- 7.00	\$ 6.00- 9.00	\$ 9.00-12.00
HOTEL SOUTHERN, S. High & E. Main Sts.		\$ 8.00 up	\$ 9.00 up
VIRGINIA HOTEL, Gay & Third Sts.	\$ 7.00- 8.00	\$10.00-12.00	\$11.00-14.00

Persons who desire additional accommodations are advised to specify their needs to the hotel of choice.
(All Rates Subject to Change)

HOTEL RESERVATION BLANK

Mail the coupon to hotel selected

Manager..... Columbus, Ohio
(Name of Hotel)

You are requested to reserve the following accommodations during the period of the Annual Meeting of the Ohio State Medical Association, May 14, 15, 16, 1957, or for such other period as may be indicated herein.

☐ Single Room with Bath ☐ Double Room with Bath Price.....
☐ Twin Bed Room with Bath ☐ Other

Arriving May..... at A. M. P. M.

PLEASE VERIFY MY RESERVATION

Name

Address.....

WARNING TO ALL MEMBERS!

Your Memberships in the Ohio State Medical Association and American Medical Association, Including Subscriptions to *The Ohio State Medical Journal* and *The Journal of the AMA*, Will Expire on December 31. Here's How To Renew Them:

It's time for all members to pay 1957 membership dues — local, state and national — unless in an exempt classification.

Mail your check immediately for dues to the **SECRETARY-TREASURER of YOUR COUNTY MEDICAL SOCIETY.**

OSMA dues are \$25.00. AMA membership dues are \$25.00. If you don't know the amount of your County Medical Society dues, check with your local Secretary-Treasurer.

Many members probably will want to send one check to cover local, state and national dues. **Make Check Payable To Your County Medical Society.** If you do tender a separate check for AMA dues, make it payable to your County Medical Society and mark on the check the words, "For 1957 AMA Dues."

Your local Secretary-Treasurer will forward state and national dues for you and other members to the Columbus Office of the OSMA. That office will transmit AMA dues to Chicago.

Remember: As a part of the privileges and Services offered to all members of the OSMA and the AMA, you will receive a year's subscription, without extra cost, to *The Ohio State Medical Journal* and *The Journal of the AMA* — or some other AMA publication of your own choosing.

Memberships and subscriptions are on a calendar year basis. Both expire on December 31. Renewal must be made by January 1, 1957, to keep them current.

Members who were exempt from paying OSMA or AMA dues, or both, in 1956 will be carried over automatically on the 1957 membership roster of both organizations unless their status has changed.

Federal Health Spending . . .

\$2½ Billion Budget for Fiscal 1957 Will Be Shared Among 21 Agencies Of the National Government; 13 Per Cent Increase Over Previous Year

FEDERAL health and medical spending for all agencies of government this fiscal year is expected to reach a new high, according to a special survey just completed by the Washington Office of the AMA. The total is placed at \$2,558,719,168, an increase of nearly 13 per cent over the last fiscal year, which itself set a new record.

The spending is spread among 21 departments, agencies and commissions concerned in whole or part with health or medicine. They range from an impressive \$825,024,300 for the Veterans Administration to a small sum of \$12,145 for running the Office of the Attending Physician of Congress.

In between is a broad range of health and medical activities, including money for implementing the many health programs inaugurated by the 84th Congress. The totals are compiled each year by the American Medical Association's Washington Office. The report, the only consolidated Federal medical budget published, is based on actual appropriations by Congress and program data supplied by the federal agencies.

\$15 PER PERSON

The medical budget total, divided into cost for each man, woman and child in the country, amounts to \$15.17 a year, while each family in the U. S. will be paying \$54.61 for this spending, based on Census Bureau figures for population, family size and employment.

Compared with last year's spending, the Defense Department has dropped to second place with its spending estimated at \$790,105,000, thus giving way to the VA. The Defense Department shift from the top spending spot, despite a \$41 million item for the new dependent's medical care program, is due primarily to more effective joint utilization of facilities, fewer personnel assigned to operation and a planned drop in hospital and dispensary construction.

HEW DEPARTMENT IS THIRD HIGHEST

Department of Health, Education, and Welfare spending for the year ending next July 1 amounts to \$772,661,800, which puts that agency's total within striking distance of the two top spenders in the health-medical field. Compared with last year's \$526,935,400, HEW spending this year is up a resounding 46 per cent, due in part to more Hill-Burton hospital construction money, record

research funds, and permanent and total disability payments.

Following is a table of spending by the 21 agencies this year and last:

Agency	Fiscal 1957	Fiscal 1956
Veterans Administration	\$ 825,024,300	\$ 790,185,800
Department of Defense	790,105,000	818,104,500
Department of Health, Education and Welfare	772,661,800	526,935,400
Federal Civil Defense Admin.	49,810,000	30,450,000
Atomic Energy Commission	31,525,000	27,700,000
International Cooperation Admin.	29,310,000	25,441,000
Department of State	15,496,000	13,669,790
Federal Employees Health Program	10,000,000	6,000,000
National Science Foundation	8,000,000	5,000,000
Department of Labor	7,151,126	7,336,000
Department of Interior	6,138,205	5,770,000
Panama Canal Zone	6,055,300	5,702,900
Department of Treasury	3,511,700	2,990,000
Department of Justice	1,580,000	1,470,000
Federal Trade Commission	1,000,000	1,000,000
Department of Commerce	547,914	277,586
Civil Service Commission	386,000	382,600
National Advisory Committee to Selective Service	180,000	180,000
President's Comm. for Handicapped	134,678	130,000
Health Resources Advisory Comm.	90,000	101,000
Office of Attending Physician of Congress	12,145	
TOTALS	\$2,558,719,168	\$2,268,826,576

Erection of a Rehabilitation Center At Ohio State Is Approved

The Board of Trustees of Ohio State University has approved erection of a building in the University Health Center, Columbus, to house the Ohio Rehabilitation Center.

The proposed building which is expected to consist of a 50-bed unit would be located north of the west end of 8th Ave., parallel to Perry St., and south of the expanded parking area for the Health Center. The new building will be financed through direct appropriations of the Ohio Legislature, as well as from such federal funds as may be available.

Dr. Ralph E. Worden is medical director of the Ohio Rehabilitation Center which is presently operating on a limited basis in space provided in the Ohio Tuberculosis Hospital on the OSU campus. Members of the Rehabilitation Board are Dr. Ralph E. Dwork, director of the Ohio Department of Health; Dr. Novice G. Fawcett, new president of Ohio State University, and Maynard Dickerson, public member of the State Industrial Commission.

ACHROMYCIN*

Hydrochloride
Tetracycline HCl Lederle

in the treatment of

genitourinary infections

UROLOGISTS report the decided advantages of oral efficacy, minimal side effects, and wide range antibacterial activity offered by ACHROMYCIN in the treatment of urinary tract infections.

Finland's¹ group of patients with acute infections of the urinary tract (principally *E. coli*) demonstrated excellent response, both clinical and bacteriological, following administration of tetracycline.

Prigot and Marmell² reported 49 out of 50 patients with gonorrhea showed a negative smear and culture on the first post-treatment visit. Purulent discharge disappeared in these patients within 24 hours after a usual 1.5 Gm. dose of tetracycline.

Trafton and Lind³ found tetracycline (ACHROMYCIN) an effective antibiotic for treating many urinary tract infections caused by both Gram-negative and Gram-positive organisms.

English, *et al.*⁴ noted that a daily dose of 1 to 1.5 Gm. of tetracycline resulted in urinary levels as high as 1 mg. per milliliter.

To suit the needs of your practice and to further the patient's comfort ACHROMYCIN is offered in a complete line of 21 dosage forms.



LEDERLE LABORATORIES DIVISION
AMERICAN CYANAMID COMPANY
PEARL RIVER, NEW YORK



*REG. U. S. PAT. OFF.

References:

1. Finland, M., *et al.*: *J.A.M.A.* 154:561 (Feb. 13) 1954.
2. Prigot, A. and Marmell, M. *Antibiotics and Chemotherapy* 4:1117 (Oct.) 1954.
3. Trafton, H. and Lind, H.: *idem* 4:697 (June) 1954.
4. English, A., *et al.*: *idem* 4:441 (April) 1954.

Medicare Program . . .

OSMA Offers To Cooperate But Finds Contract Offered by Government Unacceptable; Reasons Enumerated in Official Statement by Council

THE U. S. Government's newest medical care program will become operable throughout the nation on December 7.

Established by Public Law 569, 84th Congress, generally known as the "Medicare Program," the program will provide certain medical and hospital services at Government expense for the dependents of the uniformed services of the Federal Government. Not only will military families be covered but also the dependents of members of the Coast Guard, the Coast and Geodetic Survey, and the Commissioned Corps of the U. S. Public Health Service.

STATUS IN OHIO

This article attempts to give Ohio physicians information on the status of the Medicare Program so far as Ohio is concerned.

Also, it describes in some detail the important provisions of Public Law 569 and the directives issued by the Department of Defense and the Department of Health, Education and Welfare, each of which has been assigned certain administrative responsibilities.

Under this program, eligible dependents of officers, as well as enlisted men, will be entitled to receive certain medical services at government expense from physicians in private practice or from physicians at military facilities, and to receive hospital services from private hospitals or from hospitals at military facilities. In general—at least at the outset—the eligible dependent will have freedom of choice between civilian physicians and hospitals and military physicians and hospitals.

CASE LOAD DATA UNKNOWN

No figures have been made available to the OSMA on the number of eligible dependents in Ohio. Moreover, it is believed that no determination has been made as yet on how many, if any, dependents in Ohio will be entitled to receive medical and hospital services at military facilities in Ohio, for example, Wright-Patterson Air Force Base, Dayton, or Lockbourne Air Force Base, Columbus. Therefore, it is virtually impossible now even to guess at the potential case load of the Medicare Program in Ohio or to anticipate how the load will be divided between private resources and governmental facilities.

Although in the law there is authority to provide dependents with medical and hospital benefits under insurance contracts, the Department of Defense and the Department of Health, Education

and Welfare have decided to have the Medicare Program operate as a medical service plan.

A detailed story on Public Law 569 was published in the July, 1956, issue of *The Ohio State Medical Journal*, pages 750-751.

OFFERED OSMA A CONTRACT

Not long thereafter, medical societies, including the Ohio State Medical Association, were requested by the Government to enter into a contract proposed by the Government under which the medical societies would be responsible for certain administrative duties and were asked to make certain commitments on behalf of their members on matters relating to fees which the Government would pay for their services.

The Medicare Program and the request of the Government that the Ohio State Medical Association enter into a contract with it were first considered officially by The Council of the Association on last September 15 and 16. (See October issue, *The Ohio State Medical Journal*, pages 1065-1066.)

OFFICIAL ACTION

At a special session of The Council on November 11, The Council adopted an official statement of policy on the Medicare Program.

When reading the text of the statement which follows, note that the Association, by action of The Council, has offered to cooperate with the Government in certain respects but has declined to enter into the proposed contract submitted to it by the Government because of a "seemingly irreconcilable difference of opinion" on matters involving three basic principles.

BENEFITS WILL BE AVAILABLE

As required by law, the Medicare Program will become operable on December 7 so far as dependents of the uniformed services residing in Ohio are concerned, regardless of the action taken by the OSMA in declining to enter into a contract with the Government. Ohio dependents will start receiving benefits on that date. The Government has certain options which it can exercise in selecting an administrative agency. It can have the program, so far as Ohio is concerned, administered directly from Washington; or administered by the proper department of one of the uniformed services located in Ohio; or administered by some other organization which in the opinion of the Government would have adequate administrative personnel and facilities. In any event, eligible dependents will be able

to take advantage of the law on and after December 7.

TEXT OF COUNCIL'S STATEMENT

Here is the complete text of The Council's statement, adopted on November 11, and which has been transmitted officially to Maj. Gen. Paul I. Robinson, M. C., United States Army, who is the Executive Director of the Medicare Program having previously been commanding officer of the Letterman Army Hospital, San Francisco:

"At a meeting of The Council of the Ohio State Medical Association on September 15-16, 1956, in Granville, Ohio, The Council considered a request of the U. S. Department of Defense that the Association cooperate in establishing and operating a medical care program in Ohio for the dependents of military personnel provided for by Public Law 659, 84th U. S. Congress.

"Acting in the interests of national defense and security, The Council voted to cooperate with the Department, provided that a satisfactory agreement could be worked out between the Association and the Department of Defense.

"A committee was appointed by President Meiling, on authorization of The Council, to represent The Council on all negotiations on the Medicare Program and to report back to The Council for final review and action.

"Named on that committee were the following: President-Elect Martin; Past-President Hudson and Councilors Artman, Hopkins, Petznick and Mayfield.

This committee held several week-end long meetings, reviewing and analyzing material on the Medicare Program; discussing proposed schedules of allowances; the provisions of proposed contracts and agreements, etc.

"On invitation of the Department of the Army, which has been designated by the Department of Defense to represent the Government on all details in connection with the Medicare Program, representatives of the Ohio State Medical Association conferred with Government representatives in Washington, D. C., on November 7 and 8. This conference was attended by Doctors Meiling, Martin, Hudson, Artman, Hopkins and Petznick; Mr. Wayne Stichter, legal counsel for the Association; Executive Secretary Nelson; Mr. Charles H. Coghlan, Executive Vice-President, and Mr. Frank Van Holte, Assistant Secretary-Treasurer, respectively, of Ohio Medical Indemnity, Inc.

"Administrative details were reviewed. Legal aspects of proposed agreements between the Government and the Ohio State Medical Association were considered.

"On November 11, 1956, the committee referred to above, presented its report to The Council at a special meeting in the Columbus Office of the Association.

At the time this issue of *The Journal* went to press, information was not available for publication as to just how the Medicare Program will be administered in Ohio. Just as soon as this decision has been made by the Government an effort will be made to supply members of the OSMA with as complete data as possible about rules and regulations, procedures for dealing with the administrative agency, allowances which will be paid by the Government, description of forms which will be used, etc.

"After careful consideration of all aspects of the question, The Council made the following decisions:

"1. The Ohio State Medical Association through its committees and headquarters office staff hereby offers to cooperate with the Department of Defense on matters relating to the Government's Medicare Program in the respects enumerated below:

"A. It will lend its aid and assistance in seeing that the dependents of military personnel eligible for medical care from physicians in private practice have access to medical services of the highest quality.

"B. It will assist the Government in providing the members of the Ohio State Medical Association with detailed information about the program, how it will be administered, administrative rules and regulations, schedule of allowances which the Government will pay physicians, and similar data.

"C. It will suggest, on the request of the Department, the names of Ohio doctors of medicine to serve on an advisory committee, or committees, of the Medicare Program administrative agency.

"D. It will assist the Government in assembling data on the prevailing charges of Ohio doctors of medicine which the Department may find useful in setting up a schedule of allowances which the Government will pay for medical services to eligible military dependents.

"2. The Ohio State Medical Association is unable to enter into the proposed Medicare Program contract which has been submitted to it by the Government, because:

"A. There is a seemingly irreconcilable difference of opinion between the Department of

Defense and the Ohio State Medical Association on the following basic principles:

"(1) The principle subscribed to by the Ohio State Medical Association that it is the privilege and right of every individual doctor of medicine, after meeting the obligations imposed on him by the state licensing law and the Principles of Medical Ethics, to decide for himself how he will practice his profession.

"(2) The principle subscribed to by the Ohio State Medical Association that it is the privilege and right of every individual doctor of medicine to decide for himself whether or not a fee offered by a third party shall be accepted by the doctor as payment in full for his professional services to the patient.

"(3) The principle subscribed to by the Ohio State Medical Association that the Association has no right, legal or moral, to commit any of its members to a payment-in-full medical care program.

"B. Certain obligations which the Association would have to assume under the Medicare Program contract proposed by the Government might produce serious legal and financial problems for the Association."

ANALYSIS OF LAW AND PROGRAM

Explanations of the important provisions of Public Law 569 and the lengthy directives drawn up for implementing the act were contained in a special report prepared and issued by the Washington Office of the American Medical Association October 19.

For the information of Ohio physicians, following are excerpts from that special report:

VARYING BENEFITS

Under the law, benefits are not exactly the same in military and in private facilities; outpatient care is allowed in military but not in private hospitals; there are dollar limits on some of the benefits and service limits on others; wives and children, but not parents and parents-in-law, have a right to civilian care; virtually complete care is offered in maternity cases, but only emergency and temporary care for certain types of illness.

THOSE ELIGIBLE

Dependents of: (a) members of the uniformed services, (b) retired members, and (c) persons who died while a member or retired member are entitled by law to medical care under the new act going into effect December 7. The uniformed services are the Army, Navy, Air Force, Marine Corps, Coast Guard, Commissioned Corps of the Coast and Geodetic Survey and Commissioned Corps of the U. S. Public Health Service. However, all dependents are not entitled to civilian care.

Care from civilian as well as military sources is authorized only for spouses and dependent children of persons on active duty (but only if duty orders are for more than 30 days). Care in **military facilities only** is authorized for unremarried widow, unremarried widower and children of deceased or retired member if dependent at time of spouse's death and for parents or parents-in-law if receiving half cost of support from member at time of member's death.

Furnishing of medical care to dependents is not to interfere with primary mission of military facilities, and commanding officer of facility has conclusive determination as to the availability of space and capabilities of medical staff to care for dependents.

CARE IN MILITARY FACILITIES

In **military facilities**, medical care is limited to the following: Diagnosis, treatment of acute medical conditions, including acute phases of chronic diseases; surgical conditions; contagious diseases; immunization; obstetrical and infant care; other acute emergencies (temporary treatment); dental care **only** to relieve pain and suffering or as a necessary adjunct to medical or surgical treatment, or in U. S. where adequate civilian dental facilities are not available.

Medical care is **not** authorized in military facilities for the following: Chronic diseases; nervous and mental disorders; elective medical and surgical treatment, such as cosmetic surgery; domiciliary care; prosthesis, except that overseas and in remote places in U. S. these items may be supplied at cost; ambulance service except in emergencies; home calls (except if determined to be medically necessary); dental care except as noted above. (Exceptions allowed in special and unusual cases.)

CARE FROM CIVILIAN RESOURCES

In **civilian facilities**, medical care limited to the following: acute medical conditions, including acute phases of chronic diseases; surgical conditions; contagious diseases while in hospital; complete obstetrical and maternity care; 365 days' hospitalization (semi-private accommodations) for each admission, including all necessary services and supplies by hospital; pre- and post-hospitalization services of doctor for bodily injury or surgical operation, including certain tests; acute emergencies of any nature if threat to life, health or well-being, including temporary treatment of acute emotional disorders; diagnostic tests and procedures during hospitalization.

Payment by the government also is authorized for treatment of certain bodily injuries and a limited number of tests in connection with them when there is no hospitalization. Specifically, payment is authorized for diagnostic tests and procedures for treatment—of fractures, dislocations, lacerations and other wounds as prescribed in local schedule of allowances. In such cases

when patient is not hospitalized maximum government payment authorized is \$75 for laboratory tests, pathology and radiology examinations. Use of hospital outpatient facilities, such as cast room, for treatment of injury also is authorized.

Medical care is not authorized in civilian facilities for chronic diseases (except acute exacerbations and complications); nervous and mental disorders; elective medical and surgical treatment; domiciliary care; treatments or procedures normally considered to be outpatient care. (Exceptions allowed in special and unusual cases.)

HOSPITALIZATION RULE

While hospitalization in civilian facilities is limited to 365 days, dependents requiring hospitalization beyond this time will be transferred to service hospitals or the government may authorize pay for their continued care in the private hospital. Payment for drugs and materials outside hospital not authorized, except those dispensed by physician to patients in his office in connection with treatment of injury.

CHOICE OF FACILITY

At the outset of the program, spouses and children of active duty members (the only dependents eligible for both civilian and military care) will have free choice between civilian and military. However, this limitation can be invoked later: If it is shown that use of civilian medical facilities by dependents in a certain area has affected adversely the optimum economic utilization of service facilities, the Secretary of Defense (or of HEW) may restrict dependents in that area to care in a service facility.

In defining such areas, the secretary must take into consideration normal commuting time, distance and unusual geographic and transportation factors. Wherever imposed, this restriction on freedom of choice may be waived in an emergency, and under any circumstances spouses and children of active duty members will retain freedom of choice between service and private facilities if they are not living with the service person on whom they are dependent.

IDENTIFICATION OF DEPENDENTS

Dependents will be identified by a "Dependents' Authorization for Medical Care" card (DD Form 1173, one card to a family). In addition to identifying the individual dependents, it also will indicate whether they are entitled to both civilian or military care or only to military care on a "space available" basis. These cards will have to be in use no later than July 1, 1957. Until the new system is in effect, the services may continue to use existing procedures for identifying dependents.

Doctors and hospitals are expected to use "reasonable care and precaution" in identifying

At a meeting of the Executive Committee of Ohio Medical Indemnity, Inc., on November 18, the committee by a unanimous vote decided that it would not be feasible for Ohio Medical Indemnity to act as fiscal administrator of the Medicare Program in Ohio as had been requested by the Government. The decision has been transmitted to the Department of Defense.

dependents. However, when care is furnished in good faith and subsequently it is determined that the dependent is not entitled to such care at government expense, any action for recovery instituted by the government will be against the dependent or his sponsor, and not against the doctor or the hospital.

CHARGES AGAINST DEPENDENT

In military facilities, the charge against dependents will be \$1.75 per day for inpatient care, including cost of subsistence. As a restraint on excessive demands for outpatient care, the Secretary of Defense, on recommendation of the secretary of a service, may set uniform minimal charges for outpatient care.

In civilian hospitals, the dependent will pay the first \$25 of expense incurred, or \$1.75 per day, whichever total is the larger, payment to be made to the hospital. If the physician decides a private room or private-duty nursing care is required, a portion of the cost will be assessed against the dependent. In the case of treatment outside hospital for an injury, the patient is to pay the physician the first \$15 of costs, with the government paying the remainder as authorized by fee schedules set up by the government.

ADMINISTRATION

Secretary of Defense has jurisdiction over Army, Navy, Air Force, Marine Corps and Coast Guard when operating with Navy; Secretary of Health, Education, and Welfare has jurisdiction over Public Health Service and for medical care purposes over Coast and Geodetic Survey, and the Coast Guard when not with Navy.

In contracting for medical care, the Army is executive agent for all services in U. S., Alaska, Hawaii and Puerto Rico. The Army is empowered to arrange contracts on fees to be paid physicians; provision for review; administrative responsibility; billing arrangements; development of budgetary information; processing of complaints.

Contractors would have responsibility for

resolving medical disputes through grievance committees composed of civilian physicians.

PHYSICIANS' SERVICES

In seeking the services of physicians in private practice, an eligible dependent would have free choice of physician; at the same time, the physician would have the right to decide whether or not he desires to enter into a physician-patient relationship with the dependent under the terms and provisions of the Medicare Program.

Under the program the Government would establish a schedule of allowances it would pay for physicians' services, after consultation with medical societies. Allowances would be set up for consultants and for services in home or office in cases which subsequently result in hospitalization.

Payment is authorized for necessary diagnostic tests and procedures performed or authorized by the attending physician prior to hospitalization or for proper after-care of the same bodily injury or surgical procedure for which hospitalized but not to exceed a maximum of \$75 total charges for pre-hospitalization diagnostic tests and procedures and a maximum of \$50 total charges for post-hospitalization tests and procedures. The monetary limitations noted (\$75 and \$50) define the government's total liability, and in no way affect fees for individual procedures contained in the schedules of allowances. Mechanism is provided for payment by the government in excess of these fees in "special and extraordinary cases."

Complete maternity services include prenatal care, delivery and postnatal care in hospital, office or home.

Also authorized are allowances for (a) laboratory tests, pathology, or radiology examinations and other procedures performed or authorized by the attending physician, (b) consultant's fee if certified as required by the attending physician, and (c) newborn infant care (including immunization) outside hospital for up to 60 days.

Medical Education and Licensure Meet Scheduled in Chicago

Graduate medical education for general practice will be the topic of discussion at the opening session of the 53rd annual Congress on Medical Education and Licensure to be held February 10-12, 1957, at the Palmer House, Chicago. The three-day meeting will be sponsored by the AMA's Council on Medical Education and Hospitals, the Federation of State Medical Boards of the United States and the Advisory Board for Medical Specialties. Also scheduled for Sunday, February 10, will be a business meeting of the Advisory Board and an open meeting of the Federation.

Insurance Council Introduces Manual on Standard Surgical Nomenclature

The Health Insurance Council has introduced a standard nomenclature and classification of surgical procedures. This new manual for insurance companies, entitled "Surgical Procedures: Classification and Nomenclature," is intended to expedite the payment of claims under surgical expense insurance contracts by aiding in the adoption of a uniform terminology for surgical procedures. It does not in any way attempt to establish a schedule of physicians' charges for operations.

The booklet adapts for insurance company use the Standard Nomenclature of Diseases and Operations of the American Medical Association and is now being distributed to companies, according to Council chairman Howard A. Moreen, vice-president of Aetna Life Insurance Company, Hartford, Conn. Prepared after consultation with a committee of the AMA Council on Medical Services by the Health Insurance Council's Technical Advisory Committee, the nomenclature covers some 1,000 procedures into which practically all surgical operations may be classified.

The 58-page manual is divided into three parts. Part I contains the code of classification of nine generic types of surgery based on authoritative medical classification. Part II lists the nomenclature of procedures in medical terminology with a lay language key, while Part III presents an alphabetical index of classifications for cross-reference.

In its introduction to "Surgical Procedures: Classification and Nomenclature," the Health Insurance Council states, "It is also hoped that any new surgical schedules which may be required to keep abreast of expanding medical practice will be developed in terms of this Classification and Nomenclature. In this way, over a period of time, some standardization of the descriptions of this form of insurance may be obtained.

"The work is not directed in any way toward the establishment of either the amounts of the surgical benefits payable or the amounts of the doctors' charges for surgical procedures. Furthermore, it is not intended to suggest that surgical schedules will necessarily cover the procedures listed, particularly in the case of the substitute surgical procedures which are performed in lieu of cutting operations."

Mr. Moreen, in announcing publication of the guide, also advised that doctors and hospitals may obtain copies without charge by writing to the Health Insurance Council, Room 800, 488 Madison Avenue, New York 22, N. Y.

The Health Insurance Council is a federation of eight insurance associations whose members account for 90 per cent of the health insurance business. It serves as a central source of technical and practical information for members of the medical and hospital professions.

Tax Roundup for Physicians . . .

Most Physicians Are Liable for Returns in at Least Six Categories of Taxes; Here Is a Summary of Them, Including the Federal Income Tax

PHYSICIANS will be faced during the coming year with the task of filing returns and making payments in at least six categories of federal, state and perhaps local taxes. This article is published with the purpose of furnishing at least basic information on the following taxes with which most Ohio physicians are confronted:

(1) Federal Income Tax Law, including payroll withholdings on employees' salaries.

(2) Federal Social Security Tax including Old Age and Survivors' Insurance tax and the Federal and State Unemployment Insurance taxes.

(3) Ohio Personal Property Tax, including the tax on tangible property used in business and the tax on intangible personal property such as stocks, bonds, investments, cash and accounts receivable.

(4) Ohio Workmen's Compensation tax, required of those with three or more employees (optional for those with one or two).

(5) Ohio Sales and Use Tax.

(6) City Payroll Tax, applying to residents of cities which have such tax.

Information in this article is confined to those taxes on which the taxpayer or employer must file periodic returns. It does not include reviews of such taxes as those on real property, for which the taxpayer is billed directly, nor does it include discussion of many excise taxes for which the vendor of goods or services is primarily responsible; neither does it include a discussion of licenses.

The data and advice presented were obtained from authentic tax publications and from personal interviews with tax officials.

Nevertheless, physicians are advised to obtain supplemental advice and assistance in the preparation of their returns, from competent tax authorities or from staff members of the office of the District Directors of Internal Revenue or other appropriate agency. A tax expert may point the way to substantial savings as well as steer the taxpayer around embarrassing errors.

FEDERAL INCOME TAX

Taxpayers will pay 1956 Federal Income Taxes under provisions of the Revenue Code of 1954. Computation of this year's tax will be similar to

that of last year, since there have been no changes in the law.

FORMS AND PAYMENTS

Every person under 65 years old whose gross income for the year was \$600 or more, and every person 65 years old or older whose gross income was \$1,200 or more, must file certain income tax returns with the District Director of Internal Revenue for his district not later than April 15, 1957.

There are three types of returns, Form 1040A, Short-Form 1040 and Long-Form 1040.

Form 1040A may be used only if the income was less than \$5,000 and consisted entirely of wages reported on Withholding Statements, or such wages and not more than \$100 total of other wages, interest and dividends (excluding \$50 of dividends). When this form is used the Internal Revenue Service will figure the tax and send the taxpayer a bill or refund.

Short-Form 1040 is used if the income is less than \$5,000 and the taxpayer must include income from sources not eligible for reporting on Form 1040A; wishes to deduct from wages certain reimbursed expenses, travel, transportation, etc.; or the taxpayer wishes to deduct credits for dividends and retirement income.

Long-Form 1040 must be used if the income was \$5,000 or more, or if the taxpayer wishes to claim nonbusiness deductions that amount to more than 10 per cent of income.

INCOME-SPLITTING

Many physicians will find it to their advantage to file joint returns with their wives, whether or not the spouse has income of her own. An unmarried person who qualifies as "head of household" may claim about one-half the tax benefit afforded a married couple on a joint return.

DECLARATION OF ESTIMATED TAX

The provisions for filing declarations of estimated income taxes are principally for those persons, a substantial part of whose income is not subject to withholdings.

When filing a final return for 1956, on or before April 15, 1957, most physicians will be required to file an estimate of 1957 income.

If income from items other than wages is \$100

or less, declarations are required if the gross income from wages subject to withholdings can reasonably be expected to exceed \$5,000 in the case of a single person; or \$10,000 in the case of a married couple, head of a household or surviving spouse.

If income other than wages subject to withholdings can reasonably be expected to exceed \$100 (excluding \$50 from dividends), a declaration is required if total income including wages subject to withholdings can reasonably be expected to exceed \$600 multiplied by the number of exemptions that could be claimed on the taxpayer's return, plus \$400.

Times to file declarations of estimated tax by individuals is April 15 (or at time final return is made), June 15, September 15 and January 15. The date for filing an income tax return in lieu of a final declaration of estimated tax is January 31. Thus, if an income tax return is not filed before February 1, the last day for filing declaration or an amended declaration is January 15.

If the estimated tax paid is 70 per cent or more of the actual tax liability, no penalty is assessed. For physicians who find it difficult to estimate their income in advance, it is suggested that they use the previous year's income as a basis and later file an amended declaration if the situation changes considerably.

PHYSICIANS IN PRIVATE PRACTICE

To summarize, most physicians in private practice must comply with the following procedures:

1. On or before January 15, make a fourth quarter return on declaration of estimated income.
2. On or before April 15, file a complete income tax return for 1956.
3. Pay the difference, if any, between the income tax paid quarterly and the amount of tax liability shown on the final return. If he has overpaid, the excess will be refunded or credited against future payments.
4. On or before April 15, file a declaration of estimated tax liability for 1957, and pay either the full amount or one-fourth of it. If he elects to pay quarterly, the remaining final dates for payment are June 15, September 15 (and January 15, 1958).

ADJUSTED GROSS INCOME

Individuals who are employed and receive a salary have little difficulty in arriving at the amount of their adjusted gross income. The total salary received plus amounts received from interest, dividends, rent, or from other sources, would in such cases constitute the gross adjusted income.

The physician in private practice has more difficulty in arriving at his adjusted gross income than the person on salary. From the

amount of his cash receipt—if he reports income on the basis of cash received and disbursements, or on the amount of total charges if he uses accrual method of reporting his income—he may deduct all items of expenditure necessary in earning his income. These items are described in more detail in the following sections:

DEDUCTIBLE BUSINESS EXPENSES

Office Rental—If a physician pays rent to another person for office space, he may deduct such amount. If he rents a combined home and office, he may deduct that portion of the rent charged for the office. If he owns his own home and maintains an office in it, he **cannot** claim deduction for office rent. However, he is entitled to claim depreciation on that portion of the property occupied as an office, and the proportion of operating expenses chargeable to the office.

Automobile—The cost of repair and upkeep of an automobile, including gasoline and oil, used in professional visits may be deducted. That part of the salary paid to a chauffeur and attributable to time spent in driving his employer on professional calls, may be deducted. Sums spent for taxi hire, car fare, etc., while on professional calls, may be deducted.

Depreciation may be deducted on an automobile used in professional business. The depreciation which should be deducted annually is figured by dividing the cost price of the machine by the number of years of its usefulness. On the assumption that the useful life of an automobile is four years, the government allows 25 per cent of the cost price for depreciation each year. If a physician has one automobile which is used exclusively in professional business, he may deduct the full depreciation each year. If the machine is used only partly in professional business, the deductible depreciation should be computed on the basis of the number of miles the car is driven for professional purposes. If a physician possesses two cars, each of which is used partly in professional business the deductible depreciation on each car should be computed on the basis of the number of miles each car is driven for professional purposes.

Declining-balance method may be used on new automobile purchased after December 31, 1953, if the useful life is three years or more.

The physician should seek the advice of a tax expert as to whether or not application of the "declining-balance method" (explained in the instructions which accompany the tax forms) would be advantageous to him.

A loss occasioned by damage to an automobile maintained either for business or pleasure, which is not due to the willful act or negligence of the taxpayer, is deductible loss in the computation of net income, provided the taxpayer has not been reimbursed for such loss by insurance.

It is suggested that physicians be prepared to

substantiate claims for deductions from gross income for professional use of automobiles in case income tax officials should call on them for written records to show the mileage traveled by them in connection with professional practice, or to prove just what part of their automobile maintenance expense was a professional expense, and therefore deductible.

Professional Dues—Dues paid to professional associations to which, in the interest of his profession, the physician belongs, may be deducted.

Refresher Courses—The Bureau of Internal Revenue this year clarified its distinction between expenses for advanced education and those for refresher courses (Sec. 1.162-5 of the Internal Revenue Service regulations).

The regulation provides that expenditures for education are deductible if they are for "refresher" or similar types of courses taken to maintain the skills directly and immediately required by the physician in his employment or practice. An educational course to be covered should be designed for established medical practitioners to help them keep abreast of current developments in the profession; it should be of short duration; it should not be taken on a continuing basis, and should not carry academic credit.

Education designed to prepare the practitioner to enter a specialty will not be acceptable.

Travel Expenses—When a physician travels away from home primarily to obtain "refresher" education or to attend a medical convention for professional purposes, his expenditures for travel, meals, lodging, etc., are deductible. However, expenses for personal activities such as sight-seeing, social visiting, personal entertaining or other recreation, are not deductible. A physician who is accompanied by his wife to a medical convention may deduct the amount that the trip would have cost him alone. For example, if he and his wife have a double room, he may deduct the amount that he would have paid for a single room.

Salaries and Wages—Deductions are permitted for the salaries or wages of nurses, laboratory workers, technicians, assistants, stenographers, or other clerical workers in a physician's office so long as their duties are connected with professional work; also for wages paid maids, janitors, etc., for services rendered in connection with professional practice.

Medicine, Supplies, Etc.—Cost of medicines used in the office to treat patients, medicine dispensed, bandages, laboratory materials, chemicals and other supplies "consumed in the using" and necessary to operate the office may be deducted.

Depreciation—Depreciation may be claimed on instruments, laboratory equipment, office furniture, books, etc., of more or less permanent

value, the rate of depreciation depending on the estimated useful life of the article. A liberalized provision of the Revenue Code of 1954 permits the taxpayer to charge off a larger proportion of the cost of equipment during its early life, under certain conditions. This privilege is restricted to assets with a useful life of three years or more, and to property (1) construction of which was completed after December 31, 1953, but only with respect to that portion of the basis of such property attributable to construction, reconstruction or erection after December 31, 1953, or (2) acquired after December 31, 1953, if the original use commences with the taxpayer and commences after that date.

If improvement to offset obsolescence and wear and tear or injury has been made and deduction for the cost claimed elsewhere in the return, claim should not be made for depreciation.

Uniforms—The Internal Revenue Service permits deduction of the cost of medical uniforms (garments, etc., necessary in practice but not suitable for street wear) as business expense.

General Office Expenses—The cost of telephone, telegrams, heat, light, water, etc., used in professional services is deductible. Physicians who keep current magazines and newspapers in their waiting rooms for the benefit of their patients, may deduct this item as a business expense. The cost of professional journals for the physician's own use is also a deductible item.

Debts—If the physician's books are kept according to the "Cash Receipts and Disbursements" system, he may not charge off any unpaid debt because he is then only reporting as gross income those accounts which have proved to be good. Bad accounts have not been reported and are therefore not deductible.

If books are kept on an "Accrual Basis" (i. e., all fees, either cash or account are included in income reported for tax purpose) it is permissible to charge off all debts which have been definitely ascertained to be worthless during the fiscal year covered by the report.

The physician using the latter system must be careful to include in gross income bad debts which have been charged off in previous years but collected during the calendar year for which the return is filed.

Taxes and Licenses—State and county taxes, except those assessed against local benefits of a kind tending to increase the value of the property assessed and those imposed upon the taxpayer upon his interest as shareholder of a corporation which are paid by the corporation without reimbursement from the taxpayer, are deductible. Taxes on one's own home are not to be considered as business expenses, such taxes being allowable as nonbusiness deductions only.

Fees and expenses paid for "securing the right

to practice" are not deductible, such as the fee paid to secure a license from the State Medical Board. Other license fees which the physician is required to pay, including narcotics tax and local occupational taxes, are deductible. The cost of an automobile license, unless the car is used exclusively for business, is to be taken as a nonbusiness deduction only. The tax paid on telephone bills if the telephone is used for business only, is deductible as a business expense. This would apply to office phones. The tax paid on other telephone bills is not deductible. Federal taxes on amusements, club dues, furs and luxuries are also not deductible for Federal income tax purposes.

Federal Old Age Benefits and Unemployment Compensation Taxes paid by employers under the Social Security Act are proper deductions in making income tax returns. Such taxes are deductible in returns for the taxable year in which they are accrued or paid, depending upon the method of accounting employed by the taxpayer. Social Security taxes withheld by an employer are not deductible by the employee in computing his tax liability.

Insurance Premiums—Premiums paid for insurance against professional losses are deductible. This includes insurance against damages for alleged malpractice, against liability for injuries to a physician's automobile while in use for professional purposes, and against loss from theft of professional equipment and damage to or loss of professional equipment by fire or otherwise. Premiums paid on life insurance are not deductible.

Sales Tax Payments—The sales tax paid in connection with purchase of items used in business become a part of the cost thereof and as such are deductible as business expenses. Other amounts expended for sales tax are nonbusiness deductions and not to be taken as business expenses.

Ohio and Federal Gasoline Taxes—There is a five cents per gallon Ohio tax on gasoline, and a two cents per gallon Federal tax. These amounts are deductible. However, if a physician has already included overall cost of gasoline as part of his business expenses, the tax is not again deductible. The Ohio 5 cents tax paid on gasoline not used in business is deductible as a nonbusiness deduction. The Federal tax is deductible only as a business expense.

Interest—Amounts paid as interest on business indebtedness may be taken as business expenses. Interest items paid on personal indebtedness are deductible only as nonbusiness deductions. Interest paid to carry tax free securities may not be deducted. The interest deduction may not exceed the portion of the total carrying charges attributable to the taxable year.

Carrying charges on installment purchases up

to 6 per cent of unpaid balances are deductible where the taxpayer has carrying charge separately stated in installment sales contract.

Losses by Fire and Theft—Loss or damage to a physician's equipment by fire, theft, or other cause, not compensable by insurance or otherwise recoverable, may be computed as a business expense, and is deductible, provided evidence of such loss or damage can be produced. Such loss or damage is deductible, however, only to the extent to which it has not been made good by repair, and the cost of the repair is claimed as a deduction.

Legal Expenses—Expense incurred in the defense of a suit for alleged malpractice is deductible as business expense. However, expense incurred in the defense of a criminal action is not deductible. The cost of contesting tax liabilities is deductible.

Entertainment.—Entertainment expenses incurred as a means of enhancing a physician's practice, such as the entertainment of physicians who refer patients, and similar expenditures to attract and retain patients, are proper business expenses. The physician must be prepared to prove that such expenditures have a direct income-producing relationship to his practice; otherwise, they will be disallowed. A detailed record should be kept of each item of business entertainment expense, together with dates, amounts, names of persons entertained, the nature of the expense, and recipients of payment. Wherever possible, such expenses should be made on a charge account and paid by check so that a permanent record may be retained. The physician must be able to show from his other records the business benefit he derives from the persons he entertains. Extensive business entertainment or the expenditure of an unusually large proportion of income for this purpose makes it difficult to establish that the entire amount of these expenditures has a direct income-producing relationship to the physician's practice.

EXEMPTIONS AND ALLOWANCES

An exemption of \$600 may be claimed by the taxpayer for himself. He may also claim an exemption of \$600 for each dependent of close relationship, or for certain other dependents living in his household. To claim an exemption for a dependent, the taxpayer must have furnished over half of the actual amount used for the dependent's support in the taxable year. Scholarships do not count as income to the child in determining the extent of parental support.

Exemption also is contingent upon the dependent, other than a child, having a net income of less than \$600 for the year. A child may earn \$600 or more and still qualify as a dependent if he is under 19 or a full-time student for five months during the year, or taking on-the-farm

training, provided the taxpayer contributes more than half of his support.

An additional personal exemption of \$600 may be claimed by the taxpayer if he is over 65, another if he is blind; another if his spouse is blind; and still another if the spouse has reached the age of 65. (These provisions do not apply to dependents other than spouse.)

NONBUSINESS DEDUCTIONS

Regardless of whether or not the taxpayer claims business expenses, he may claim the following deductions if eligible to do so, **providing that there is not a duplication of deductions under the two categories.**

Contributions, Gifts, etc.—The individual taxpayer may deduct contributions up to 30 per cent of adjusted gross income, if the last 10 per cent is given to a church, an association of churches, an educational institution or a hospital. The ceiling remains at 20 per cent for contributions to other charitable organizations, no substantial part of the activities of which are carrying on propaganda or otherwise attempting to influence legislation.

Medical and Dental Expenses—The taxpayer may deduct medical and dental expenses which exceed 3 per cent of the adjusted gross income. However, in figuring these expenses, the amount paid for medicine and drugs may be taken into account only to the extent it exceeds 1 per cent of the adjusted gross income.

The deduction may not exceed \$2,500 multiplied by the number of exemptions other than the exemptions for age and blindness. In addition there are maximum limitations as follows: (a) \$5,000 if the taxpayer is single and not a head of household or a qualifying surviving widow or widower; (b) \$5,000 if the taxpayer is married but files a separate return; or (c) \$10,000 if the taxpayer files a joint return, or is a head of household or a qualifying surviving widow or widower.

If the taxpayer or his wife is 65 or over, the maximum limitations are the same as in the foregoing paragraph. However, amounts deductible for medical and dental expenses are not restricted to the excess over 3 per cent of adjusted gross income. In effect the 3 per cent rule may be disregarded. But the amounts spent for medicine and drugs are still limited to the excess of 1 per cent of income, and amounts spent for dependents' medical expenses are deductible only to the extent they exceed 3 per cent of adjusted gross income.

Medical expenses paid by an estate within one year after death are considered paid by the decedent.

The term "medical care" is broadly defined to include "amounts paid for the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or

function of the body (including amounts paid for accident or health insurances)."

In regard to payment of premiums on accident and health insurance, the Internal Revenue Service has ruled that premiums may be deducted for insurance that provides for indemnity for the cost of medical care and specific injury, but may not be deducted for insurance which indemnifies the holder solely for the loss of earnings.

In order to obtain this credit for medical and dental expenses, the taxpayer is required to list the name and address of the person to whom the payment is made, the approximate date of actual payment and amount. It should be noted that this will furnish the Internal Revenue Service with data which can be used in checking returns filed by physicians and dentists—another reason why they should keep accurate records and compile their returns carefully.

Interest—The taxpayer may deduct interest on a personal note to a bank or individual, a mortgage on his home, a life insurance loan if the interest is paid in cash, or interest on delinquent taxes.

Taxes—Deduction may be made for taxes paid on personal property or real estate, for city income taxes, retail sales taxes, auto license fees, state gasoline taxes.

Casualty Losses and Thefts—The taxpayer may deduct losses due to destruction of property by fire, stolen property or cash, and storm damage, if not claimed as a business deduction and not covered by insurance.

OPTIONAL STANDARD DEDUCTION

The optional standard deduction permitted in lieu of listing amounts paid for contributions, interest, taxes, and other nonbusiness deductions is 10 per cent of the adjusted gross income, but not in excess of \$1,000, or \$500 in the case of a married person filing a separate return.

PARTNERSHIPS

The partnership itself is not subject to income tax, but is required to file an information return. The tax liability falls upon the individual partners. Partnerships may be simple agreements by which two or more physicians share expenses and prorate income. On the other hand, they may be elaborate entities. Since there are many special regulations pertaining to partnerships, partners would do well to seek expert advice.

RETIREMENT INCOME

Retirement income, including pensions, annuities, interest, rents, dividends, etc., are subject to special treatment under the income tax laws.

DISTRICT OFFICES AND DISTRICTS

Income tax payments and returns must be made at or mailed to the office of the District

Director of Internal Revenue for the district in which the taxpayer has his legal residence. There are four internal revenue districts in Ohio. The counties comprising each district follow:

For the Columbus District (Ohio 11th) Director of Internal Revenue, 110 W. Long St., Columbus; comprising the following counties:

Adams, Athens, Coshocton, Delaware, Fairfield, Franklin, Gallia, Guernsey, Hocking, Jackson, Knox, Lawrence, Licking, Madison, Marion, Meigs, Morgan, Morrow, Muskingum, Noble, Perry, Pickaway, Pike, Ross, Scioto, Union, Vinton and Washington.

For the Cleveland District (Ohio 18th) Director of Internal Revenue, 626 Huron Rd., Cleveland; comprising the following counties:

Ashland, Ashtabula, Belmont, Carroll, Columbiana, Cuyahoga, Geauga, Harrison, Holmes, Jefferson, Lake, Lorain, Mahoning, Medina, Monroe, Portage, Richland, Stark, Summit, Trumbull, Tuscarawas and Wayne.

For the Cincinnati District (Ohio 1st) Director of Internal Revenue, Post Office Building, Cincinnati; comprising the following counties:

Brown, Butler, Clark, Clermont, Clinton, Fayette, Greene, Hamilton, Highland, Miami, Montgomery, Preble and Warren.

For the Toledo District (Ohio 10th) Director of Internal Revenue, Toledo; comprising the following counties:

Allen, Auglaize, Champaign, Crawford, Drake, Defiance, Erie, Fulton, Hancock, Hardin, Henry, Huron, Logan, Lucas, Mercer, Ottawa, Paulding, Putnam, Sandusky, Seneca, Shelby, Van Wert, Williams, Wood and Wyandot.

INCOME TAX WITHHOLDINGS

Every employer who pays wages to one or more employees, where an employer-employee relationship exists, must withhold from such wages and pay over to the Federal Government periodically an amount prescribed by law.

The amount to be deducted from each pay check may be determined by referring to the *Employer's Tax Guide Circular E* after having the employee fill out Form W-4 to determine the number of exemptions he claims. The handbook is supplied by the District Office of the Director of Internal Revenue.

The amount deducted is paid to the District Office of the Director of Internal Revenue together with report on Form 941, quarterly during the month immediately following the quarter for which deductions are made. (Social Security taxes are reported on this same form.)

The employer is required to give each employee from whose wages he has withheld income tax during the year a statement in duplicate showing the amount of tax withheld and wages

paid for that year. Forms W-2 in quadruplicate are supplied for this purpose. The original copy of Form W-2 is to be filed with the Employer's Quarterly Federal Tax Return, Form 941, for the last quarter. The second and third copies are furnished the employee and the fourth copy retained by the employer for his records. Statements must be furnished employees and reports made to the government between January 1 and January 31, for the previous year.

DEPOSIT OF WITHHOLDINGS

An employer who withholds as much as \$100 per month for the purposes of income tax liability and F. I. C. A. liability (employer's and employee's shares) shall take these funds with Form 450 to a bank and deposit them. The bank transmits this form to the Federal Reserve Bank in Cleveland for validation, after which it is returned directly to the employer. The depository receipt, Form 450, is then eligible for use.

REPORT OF FUNDS PAID

As in previous years, payments in excess of \$600 made during the year for interest, rents, or commissions, not subject to withholdings and paid to anyone other than a corporation, must be reported on Form 1099 and transmitted with Form 1096, on or before February 15 of the following year to the Director of Internal Revenue, Processing Division, Kansas City, Mo.

SOCIAL SECURITY TAXES

The Federal Social Security Act embodies laws pertaining to Old Age and Survivors' Insurance and Unemployment Insurance. Because the procedures for paying these taxes are different, they are discussed here under separate headings.

A person 65 years old or older who is receiving Social Security benefits may now earn up to \$1,200 a year without losing his benefit. For any excess earnings over \$1,200 he may lose one month's benefits for each \$80 or fraction thereof. A person 72 or older may earn any amount and continue to draw benefits.

Not covered for social security purposes are services performed by an individual in the employ of his son, daughter, or spouse, and services performed by a child under 21 in the employ of his father or mother.

Under provisions for coverage of self-employed workers, physicians are specifically excluded.

Domestic workers in private homes who receive wages of at least \$50 in a quarter are covered. In other words, if a taxpayer has a cleaning woman, or other domestic worker, only one day a week, she must be covered if she earns \$50 or more in a quarter (approximately \$3.85 per week). Domestic workers in farm homes come under the same provisions as farm workers.

A farm worker who earns \$150 in cash wages

during the year must be covered. However, farm workers who perform agricultural services for an employer for 20 or more days during a calendar year for cash at a rate based on some unit of time must be covered regardless of the rate.

Only cash is considered in wages paid to domestic or farm workers, not wages in kind.

OLD AGE AND SURVIVORS' INSURANCE TAX

The Old Age and Survivors' Insurance Tax is payable by every employer who employs one or more persons in his office or home.

The Social Security Amendments of 1956 will make a change in the OASI tax. Beginning January 1, 1957, the employer will deduct $2\frac{1}{4}$ per cent of the employee's wages at each pay period and contribute a like amount himself. (The rate through December 31, 1956, is 2 per cent for each.) Payments are made on the first \$4,200 of annual salary only.

The tax return and informational return, combined in one report, is to be filed quarterly. The tax must be paid and the return filed on or before April 30, for the months of January, February and March of that year, in the office of the District Director of Internal Revenue, and quarterly thereafter, payable during the month after the quarter ends.

The employer who hires household help only should file on Form 942, which is in the form of an envelope for convenient mailing. The employer who reports his office workers on Form 941 may add his domestic workers to this same form.

Farm workers must be reported on Form 943.

UNEMPLOYMENT TAX

Physicians or other employers who have three or more employees, including other physicians, nurses, receptionists, technicians, office workers, etc., are subject to the Ohio Unemployment Compensation Tax. Those who have four or more are liable also for the Federal Unemployment Insurance Tax.

OHIO UNEMPLOYMENT COMPENSATION TAX

In general, employment of three or more persons in any one day including part-time workers renders the employer liable for this tax. A physician who is in doubt as to his liability, should request clarification from the Bureau of Unemployment Compensation, 427 Cleveland Ave., Columbus 16.

Reports are made during the month following each calendar quarter on forms supplied by the Bureau. The tax rate is established for each employer annually. A copy of the calculations made by the Bureau is mailed before the first of the year to each employer. This shows how the rate for the employer for that year was calculated. This rate starts at 2.7 per cent and may

be reduced to as low as one-tenth of one per cent. Only the first \$3,000 paid by any employer to any one individual within a calendar year is taxable.

Liable employers should furnish a form BUC-400 to each employee upon separation. These forms may be obtained from the local employment office. If the employee files a claim for benefits, the Bureau will request separation and wage information from the employer. It is imperative that this form requesting separation information be returned to the Bureau within seven days of its receipt.

FEDERAL UNEMPLOYMENT TAX

The Federal Unemployment Insurance Tax applies to employers who have had four or more persons on their payrolls on 20 or more days in the calendar year, each of the 20 days being in different calendar weeks. It is payable to the District Director of Internal Revenue by January 31 for the previous year. The gross tax is three per cent on all individual wages up to \$3,000 and is paid exclusively by the employer—the employee making no contribution. A credit not to exceed 90 per cent of this tax is allowed on all payrolls which were reported to the state unemployment compensation agency (see under Ohio Unemployment Compensation Tax) and the state tax paid by January 31. If an employer has paid his state unemployment tax in full, the Federal tax is reduced to three-tenths of one per cent.

OHIO WORKMEN'S COMPENSATION

The purpose of the Bureau of Workmen's Compensation is to maintain a Workmen's Compensation Insurance Fund from which to pay compensation to workmen for injury or occupational disease and compensation to dependents for death occasioned in the course of or arising out of employment.

Every employer in the state employing three or more employees regularly in the same business is required to furnish the Bureau of Workmen's Compensation with specified information about employees he has had during the previous year, and to contribute to the State Insurance and Occupational Disease Fund in an amount based on the payroll and at a premium rate based on the class of risk. (The employer under certain circumstances may elect under bond to comply with the provisions of the law by self-insuring the risk.)

Employers of less than three employees may voluntarily subscribe to and obtain insurance in the Fund.

Insurance accounts are adjusted and reports made for the first half and second half of the calendar year. Reports are due with premiums attached by September 1 for the first half of the year, and by March 1 for the second half of the

year. Another requirement is an advance permanent deposit based on eight months estimated payroll for the periods January 1 - August 31 and July 1 - February 28, respectively.

The Bureau of Workmen's Compensation during the past year or more has undergone a decentralization program. The Bureau now comprises 16 regional offices in addition to the central office in Columbus.

OHIO PERSONAL PROPERTY TAX

Returns under the Ohio Personal Property Tax Law must be made between February 15 and March 31 annually. One-half of the amount of the tax is paid when the return is filed, and the other half is due September 20.

It must be kept in mind that tangibles to be listed include personal property used in business, such as a physician's office furniture, fixtures, equipment, supplies (including medicines), etc. Such tangible property should be listed at its book value. A depreciation of 10 per cent annually from cost will be allowed until such equipment reaches a value of 30 per cent. It should stop at that figure for a year. Then such office equipment may be reduced 5 per cent each year until it reaches a minimum value of 20 per cent, which value should be kept as a utility value.

Form 937, obtained from the Ohio Department of Taxation must be filed with the Personal Property Tax return to obtain a lesser value than 30 per cent.

Returns should be filed in duplicate. The so-called tangible tax statutes are intricate and complicated so each physician having taxable personal property for listing should obtain competent advice in case of doubt as to the meaning of any of the provisions of the law.

One of the complicated provisions of the tax law is that involving the listing of credits which are taxable at 3 mills on the dollar and which involves the computation of accounts receivable.

Accounts receivable are to be listed in accordance with Section 5711.18 of the Revised Code part of which reads, "Claim for any deduction from net book value of accounts receivable or depreciated book value of personal property must be made in writing by the taxpayer at the time of making return," on supplementary tax form 902.

As defined in Section 5701.07 R. C., credits "mean the excess of the sum of all current accounts receivable and prepaid items used in business when added together estimating every such account and item at its true value in money, over and above the sum of current accounts payable of the business, other than taxes and assessments."

The same section states that "current accounts include items receivable or payable on demand or within one year from the date of inception, however evidenced."

To arrive at a fair estimate of his current accounts receivable, the physician is advised to note after each account what he considers its value. If he believes the account can be collected in full, it should be listed at its full face value. Otherwise it should be listed at a percentage of its true value, or "no value" if that is the case. The total of these estimates is the amount to be entered as "current accounts receivable" and used in computing credits.

This procedure permits the physician to charge off bad debts. It also allows him to depreciate the actual value of accounts returned in the tax year, but which have decreased in actual value during that year.

Some physicians misunderstand the provision requiring the listing of accounts receivable for taxation. Some think that physicians are the only ones who have to do so and that the law is discriminatory. That is not true.

Every person who possesses intangible assets, such as accounts receivable, or any business or professional man who does business on credit basis and keeps books, must return his accounts receivable for taxation.

Such person must keep in mind that he can estimate depreciation on his accounts receivable and that he can use *accounts payable* as an offset against accounts receivable, paying the tax on the difference.

Obviously, the percentage discount used by a physician in depreciating the value of his accounts receivable will depend to a large extent on the doctor's collection experience and on the economic status of the majority of his patients. In other words the physician who has difficulty in collecting bills or whose practice serves a large number of persons in the low-income brackets or who are poor credit risks, should use a higher depreciation formula than the physician who does not have these factors to contend with.

OHIO SALES AND USE TAX

Section 5739.02 Revised Code levies an excise on each retail sale made in Ohio of tangible personal property.

The Ohio Use Tax Law, passed in 1936, supplements the Retail Sales Tax Law and imposes a tax on the same basis as the sales tax on purchases made outside the State. Its purpose is to protect Ohio merchants from discrimination. Many out-of-state firms have made arrangements with the Ohio Department of Taxation to add the amount of the tax to invoices covering purchases by Ohio consumers, collecting the tax and paying it directly to the Department.

However, if a physician purchases drugs or supplies from an out-of-state firm which has not made such an arrangement with the Tax Department, he is required to report such purchases to

the Treasurer of State and pay the tax. Returns must be filed with the Treasurer by next April 15 for purchases, during the period January 1 to March 31, and quarterly thereafter. The report is filed on Ohio Use Tax Form 1014, "The Quarterly Consumers Return."

Section 5739.01, Revised Code, contains this provision: "Physicians, dentists, hospitals, and blood banks operated by non-profit institutions are consumers of all tangible personal property purchased by them in connection with the practice of medicine, dentistry, or rendering hospital or blood bank service. They shall not be required by any provision of Sections 5739.01 to 5739.31, inclusive, and 5741.01 to 5741.22, inclusive, of the Revised Code, to collect sales or use tax on property transferred by them to patients in connection with the rendition of professional services provided that if physicians, dentists, and hospitals are engaged in selling to consumers tangible personal property as received from others, such as eye glasses, mouth washes, dentifrices, or similar articles, the tax shall apply to such sales."

CITY PAYROLL TAX

Several cities in Ohio have enacted laws imposing income tax on wage earners and making the employer responsible for deducting the tax from wages paid employees. For example, Columbus has a law which requires the employer to deduct a percentage of the employee's wages and make returns to the city auditor quarterly. A physician who moves into a new location should inquire as to what tax laws may be in force locally.

Cincinnati Will Be Scene of National Health Forum

Cincinnati will be host to the 1957 National Health Forum, sponsored by the National Health Council, March 20-22, at the Hotel Hilton Plaza. The theme of the program will be "Better Mental Health—Challenge to All Health Services."

Dr. Francis J. Braceland, chairman of the committee of 23 who are planning the program for the forum, explained the theme by saying, "The Forum will seek to outline what we now know about how to foster mental health and to encourage more effective use of that knowledge." The forum is one in an annual series conducted by the National Health Council in behalf of its 51 organization members.

Additional information may be obtained from the National Health Council, 1790 Broadway, New York 19, N. Y.

Closely associated with this program will be a meeting of the National Advisory Committee on Local Health Departments in Cincinnati on March 19.

Still Time for Contribution to Medical Education Fund

Last year nearly 3,000 Ohio physicians contributed \$122,000 to the cause of medical education, either through the American Medical Education Foundation or directly to the Alumni Funds of their own medical schools. Only a few weeks remain in the 1956 campaign. The medical schools must have more private funds for operating purposes in order to insure their freedom. Remember that such donations are income-tax deductible, and that you can ear-mark your AMEF donation for your own school. The address is: 535 N. Dearborn St., Chicago, Illinois.

Those Eligible for Mead Johnson Awards Asked To Contact AAGP Headquarters

Any physician who is in an internship or in military service and can start a residency in July is eligible to apply for a Mead Johnson Award for Graduate Training in General Practice.

Application blanks are available, on request, from the American Academy of General Practice, Volker Boulevard at Brookside, Kansas City 12, Missouri. Applications should be completed and returned to the AAGP office prior to February 1, for residents desiring to start training the following July.

The fund, created in 1950 by Mead Johnson & Company, Evansville, Indiana, allows for an annual award of \$1,000 to each of 10 medical graduates to aid them in taking a residency in general practice. The ten winners are selected by the Mead Johnson Award Committee on the basis of scholarship, professional aptitude and fitness for general practice.

The desirability of formal training beyond a one-year rotating internship becomes even more important with the new requirements for membership in the American Academy of General Practice. All new Academy members must now have completed at least one year of rotating internship or the equivalent in postgraduate training, and must have completed (1) two years of graduate training acceptable to and approved by the Commission on Education, or (2) one year of graduate training followed by two years of general practice, or (3) three years of general practice.

In 1956, two Ohio physicians started their training in hospitals with approved general practice residencies—with the assistance of Mead Johnson scholarship awards. They were: Richard B. Juergens, M. D., Mercy Hospital, Toledo, and John E. Loudenslager, M. D., City Hospital of Akron.

In Our Opinion:

Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

SUGGESTED FOLLOW-UP ON LOCAL ELECTIONS

Ohio's county medical societies will find it of value to "follow up" on the November elections. How this should be done hinges on the outcome of their local elections.

If the candidates the local society supported were successful, then expressions of congratulations and offers of continued support should be sent to the successful candidates. Now is the time to strengthen contacts with the office holders.

If issues the local society supported were defeated, there is more to be done.

First, express appreciation to supporters. Second, analyze the local campaigns and how they were conducted. Try to determine why an issue failed.

If there were mistakes and oversights, evaluate them and be prepared to avert such pitfalls in the future.

Before the election, the watchword was, "Know your candidates and the issues." Now that the election is over, the watchword is, get to know your elected officials—and see that they know you.

BEST PREVENTION MAY BE EDUCATIONAL CAMPAIGN

The suggestion of an Ohio physician, who also is a county coroner, that specially trained medical teams may be a part of the answer to the problem of preventing traffic deaths is worthy of consideration.

And there is no argument with the editorial writer of a leading Ohio newspaper who wrote of the well-meaning but non-medical, bumbling amateurs who, with good intentions but often bad results, attempt first aid on traffic victims without even a rudimentary knowledge of first aid.

Local medical societies would, in our opinion, find it a worthwhile project to institute, with the cooperation of traffic officials, hospitals and interested groups, a series of educational meetings designed to prevent such bumbling.

By staging a campaign to acquaint the public with the fact that the accident victim should not be moved until he is under the supervision of a physician, local societies can perform a public service.

Those conducting such a program might impress upon the public the dire results often seen when the traffic victim is moved without medical supervision. Most people, in an emergency, feel that they should do something immediately. They

should be taught that the "something to do" is to leave the victim as he is. It should be impressed upon them that this is "doing the right thing."

MEDICAL SCHOOLS JOIN 'DO-IT-YOURSELF' TREND

The 76 approved four-year medical schools in the U. S. are joining the "do-it-yourself" move. At least, they are encouraging medical students to do so by placing on the students greater responsibility for their own training.

A recent AMA report said this change is in the direction of individualizing instruction and providing opportunities for learning, for self-development, and for independent work.

"The aim," the report said, "is to develop minds capable of appraising evidence and drawing conclusions based on logical reasoning . . . which will prepare the student to continue his own self-education throughout his professional life."

In our opinion, any changes which will keep medical education from becoming a stereotyped, cut-and-dried procedure will be to the advantage of everyone concerned, including the public.

DON'T TAKE INSURANCE COMPANY AT FACE VALUE

An experienced insurance broker warns: Don't buy insurance from a firm not licensed in Ohio. This is sound advice.

The warning applies to any type of insurance, whether it be life, auto or property. If the firm is not licensed in Ohio, you may not collect a cent on a perfectly legitimate claim, according to the broker, because you lose all rights under the Ohio insurance law. You may pursue your claim in the state where the company is licensed, but how many claims involve enough to make such an effort worthwhile?

Four good rules of measure for an insurance company are (1) is it licensed in the state, (2) is it represented by a resident of your community, (3) does it have sufficient reserves, and, (4) does it pay its just claims promptly and in full?

Check on these points before buying a policy. One might say that to do this is "good insurance against bad insurance."

PATIENTS'LL LIKE YOU BETTER IF YOU'LL JUST EXPLAIN

Looking for a doctor well-liked by his patients?

Find the doctor who carefully explains the patient's case to him in lay terms.

Failure to understand their doctor and his ac-

FOR POSITIVE DIURESIS

ROLICTON*

- oral b.i.d. dosage
- continuous control of edema

The new, highly effective oral diuretic, Rolicton, greatly simplifies the task of maintaining an edema-free state in the patient with congestive heart failure. Rolicton meets the criteria for a dependable diuretic: continuous effectiveness, oral administration and clinical safety.

In extensive clinical studies the diuretic response clearly indicates that a majority of patients can be kept edema-free with Rolicton. In these investigations it was noted that side reactions were uncommon. When they did occur they were usually mild.

In most edematous patients Rolicton may be employed as the sole diuretic agent. When used adjunctively in severe cases, Rolicton is also valuable in eliminating the "peaks and valleys" associated with the parenteral administration of mercurial diuretics.

One tablet of Rolicton b.i.d., after meals, is usually adequate for maintenance therapy after the first day's dosage of four tablets. Some patients respond well to one tablet daily. G. D. Searle & Co., Chicago 80, Illinois. Research in the Service of Medicine.



*Trademark of G. D. Searle & Co.

SEARLE

tions too often are the complaints of patients. The doctor who in lay terms paints a clear, lucid picture of the case for the patient is accomplishing at least two goals.

First, he is gaining the appreciation and the gratitude of the patient.

Second, he most likely is eliminating the nervous tension often arising in the patient who worries because he knows only that he is sick, knows not why he is sick and knows not what is being done to make him well.

Such a policy is of course demanding of the physician's time. Too many patients know the diagnoses of their ills but need to be told what is wrong with them.

The ingredients for successfully establishing such a policy with patients are few and include:

An ability to see the patient's desire for explanation; adequate means of developing the explanation; taking time to present the explanation to the patient.

MEDICINE, TO ADVANCE, NEEDS ATMOSPHERE OF FREEDOM

Those interests which advocate state medicine would do well to heed the penetrating statements made in an editorial appearing in the *Miamisburg* (Ohio) *News*.

While the editorial deals with preventive medicine, its contentions apply equally well to all phases of medicine. Particularly noteworthy are the conclusions drawn in the editorial:

"It is worth noting that preventive medicine has suffered most in countries where medicine is either socialized or controlled by government. Writers on England's national health system have pointed to this. Doctors in such countries are often overworked. They lack the time for study, experiment, and research. And the bureaucrats who make the rules and issue the orders have small interest in projects which may not produce results for long periods of time.

"Progress in medicine—like all progress—flourishes in an atmosphere of freedom, and withers in an atmosphere of coercion."

HOSPITALS NOT IMMUNE TO INFLATION SPIRAL

Repeated rate increases are creating serious public relations and financial problems for hospitals. Administrators contend that higher wages and shorter hours for employees are principally responsible.

They are faced with competition from business in that business employment of women has increased considerably in the past 20 years, one administrator points out.

Another reason given—and this one may bring some surprise—is that there is a more rapid turnover in bed occupancy. In other words, bet-

ter medicine has appreciably reduced the extent of hospitalization of the patient. Beds which do not produce income, if for just one night, cost the hospital money.

Hospital administrators are asking the doctors to explain the situation to their patients in a manner that will be understood. This they should do. However, the question might be asked:

What manner of program do the hospitals have in "selling" their rate increases? It would appear that hospitals could and should do more than just present the patient with an itemized bill when he is discharged.

WHAT TO WRITE FOR

Some booklets, pamphlets and other published material available for the asking or at nominal expense and suitable for the physician's office, library or waiting room, or for his personal information.

* * *

Manual of Serologic Tests for Syphilis—1955 Edition—assembles latest technical procedures in performance of tests now commonly employed in the United States. This manual, Public Health Service Publication No. 411, is obtainable for a dollar, from Superintendent of Documents, U. S. Government Printing Office, Washington 25, D. C.

* * *

It's High Time. Booklet for parents, containing tips on handling teen-agers, their fads, use of cars, study habits, dating, allowances, chores, etc. Available for 50 cents from National Education Association, 1201 - 16th Street, N. W., Washington 6, D. C.

* * *

X-Ray Protection. Contains recommendations of the National Committee on Radiation Protection for planning surveys, inspections, working conditions and plans for an X-ray installation, plus rules for specific applications (20 cents). Write Superintendent of Documents, Government Printing Office, Washington 25, D. C.

* * *

Public Health and Social Problems in the Use of Tranquilizing Drugs. Monograph describes large variety of scientific facts needed to assess public health and social problems that may result from widespread use of tranquilizers (25 cents). Write Superintendent of Documents, Government Printing Office, Washington 25, D. C.

* * *

Estimation of Loss of Visual Efficiency. The 1955 revision of methods approved by the House of Delegates of the AMA in 1940. Available from the Council on Industrial Health, American Medical Association, 535 North Dearborn St., Chicago 10.



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*Constructive Medicine in Aging:
Cardiovascular Disorders in the Aged*

*Thursday, January 17, 1957, 9:30 A.M. to 5:00 P.M.
Hall of Mirrors, The Netherland Hilton, Cincinnati, Ohio*

PROGRAM

Johnson McGuire, Professor of Clinical Medicine and Director of Cardiac Laboratory, University of Cincinnati College of Medicine, will serve as moderator for the Symposium

K. J. Franklin, The Medical College of St. Bartholomews Hospital, London.
INVESTIGATION OF WHAT IS CONSIDERED NORMAL FOR THE AGING CARDIOVASCULAR SYSTEM

J. Earle Estes, Jr., Mayo Clinic, Rochester, Minnesota.
VENOUS DISORDERS IN OLDER PEOPLE

Walter S. Priest, Associate Professor of Medicine, Northwestern University School of Medicine, Chicago.
ANTICIPATION AND MANAGEMENT OF CARDIAC DECOMPENSATION

Jessie Marmorston, Professor of Experimental Medicine, University of Southern California, Los Angeles.
HORMONAL ASPECTS OF MYOCARDIAL

INFARCTION IN FEMALE AND MALE SUBJECTS

Ancel Keys, Professor of Physiology and Director of Laboratory of Physiological Hygiene, University of Minnesota, Minneapolis.

CALORIES AND CHOLESTEROL

Robert W. Wilkins, Professor of Medicine, Boston University School of Medicine, Boston.

DRUG THERAPY FOR HYPERTENSIVE VASCULAR DISEASE IN PATIENTS PAST MIDLIFE

Robert A. Bruce, Associate Professor of Medicine, University of Washington School of Medicine, Seattle.

EVALUATION OF FUNCTIONAL CAPACITY IN PATIENTS WITH CARDIOVASCULAR DISEASE

Edward J. Stieglitz, Consultant in Geriatrics, Veterans Administration and St. Elizabeths Hospital, Washington, D. C.

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Washington Roundup . . .

News From Nation's Capital of Interest to Physicians; Reports of Developments in Medical and Health Fields; Activities of Agencies

Surgeon General Burney has urged step-up of polio vaccinations. Manufacturers have some 17 million cc. of vaccine on hand. Burney has suggested completion of three-injection schedule, extension of program to young adults, especially parents of young children, and efforts to immunize teenagers.

* * *

Public Health Service has established a new activity Center of Research for Aging, with its objectives being problems of the aging population. Through the center, PHS will offer financial support to universities and other organizations for research on medical problems of the aged.

* * *

Federal Civil Defense Administration is re-evaluating casualty care program as result of tests last April and June, which showed it was necessary to plan for more immediate casualties and for longer hospitalization after an attack.

* * *

Some 30 million persons in 1,400 communities throughout the nation are drinking fluorinated water, according to latest U.S. Public Health Service statistics.

* * *

Post Office Department has entered the picture in the battle against medical quackery. Department is deluged with complaints of fraud involving instances where mails are used to make sales. Target is false advertising for such nostrums that promise "enlarged bosom," revive "lost manhood," purify "bad blood" and banishment of chronic diseases.

* * *

Democrats retained control of Congress in November elections, which means there will be few changes in chairmen of committees important to medicine.

* * *

Scientific evidence of increase in toxicity when some compounds of organic phosphate insecticides are used on food crops has prompted Food and Drug Administration to take steps to tighten safety controls over residues of those chemicals.

* * *

Nationwide report on geographic distribution, made recently by Public Health Survey, shows some 4.1 general hospital beds and 1.3 skilled nursing home beds per 1,000 population in metropolitan counties in proportion to 1.8 hospital beds and .4 nursing home beds per 1,000 population in isolated, rural counties. Study

showed number of doctors and nurses, along with per capita income increases, had direct relation to increases in number of beds.

* * *

Health insurance and other fringe benefits in 1955 costs U.S. employers an average of \$819 per employee, reports U. S. Chamber of Commerce.

* * *

National Institute of Neurological Diseases and Blindness plans full research treatment for cerebral palsy and mental retardation, with budget of more than \$1 million a year for the next 10 years.

Estimated 8 Million Ohioans Protected In Some Way by Health Insurance

The number of people in Ohio who are covered by voluntary health insurance reached a new high by September 30, the Health Insurance Council reported. As of that date the Council estimates that 8,000,000 persons were protected by some form of insurance designed to help pay hospital and doctor bills.

This figure, the Council said, is part of the continued growth of health insurance throughout the country, which was revealed last August in its tenth annual survey of the extent of voluntary health insurance coverage for 1955. The number of people covered by some form of health insurance in the nation stands at the 110 million mark.

In releasing the findings of its survey, which is based on reports of insurance programs of insurance companies, Blue Cross-Blue Shield and other health care plans, the Council went on to say that there were 7,743,000 persons covered by hospital expense insurance in Ohio as of December 31, 1955. This represents a gain of 333,000 over the 1954 total of 7,410,000 persons.

Surgical expense insurance, which helps to defray the cost of physicians' charges for operations rose to 5,998,000, as compared with 5,665,000 the year before, a gain of 333,000 persons.

The number of people protected by regular medical expense insurance, providing doctor visits for non-surgical care, during 1955 rose to 2,392,000 as against the previous year's figure of 1,809,000, reflecting an increase of 583,000 persons covered.

The Health Insurance Council is a federation of eight insurance associations, representing approximately 90 per cent of the accident and health insurance business.

District Meetings . . .

Among the Excellent Fall Postgraduate Programs in Ohio This Fall Were Meetings Representing Physicians of Four Councilor Districts

ALL postgraduate programs have become a tradition in several of Ohio's Districts. This season three such meetings were held with great success, as reported by those who attended. The Northwestern Ohio Medical Association, representing physicians of the Third and Fourth Districts met at Bowling Green. The Sixth District meeting was held this year at Youngstown and the Eighth District program at Cambridge.

* * *

Traditional Northwestern Ohio Meeting Held This Year at Bowling Green

Meeting for its 112th scientific assembly, the Northwestern Ohio Medical Association met this year at Bowling Green on October 17. The Association is composed of physicians of the Third and Fourth Councilor Districts.

An attendance of between 160 and 170 persons were present for the assembly.

The following officers were elected: Dr. Floyd A. McCammon, Van Wert, president; Dr. Thomas D. Efstation, Tiffin, vice-president; Dr. Frank M. Wiseley, Findlay, secretary; Dr. D. J. Slosser, Defiance, treasurer.

An excellent scientific program was held, with a special talk on the role of the community hospital in disaster planning by Anthony W. Eckert, of Perth Amboy, N. J.

During the business session, brief remarks on organizational matters were made by Dr. James R. Jarvis, Van Wert, Councilor of the Third District; Dr. Paul F. Orr, Perrysburg, Councilor of the Fourth District, and Mr. Charles S. Nelson, Columbus, Executive Secretary of the Ohio State Medical Association.

The group voted to hold the 1957 meeting in Defiance on a date to be determined later.

* * *

Sixth Council District Postgraduate Day Draws Attendance of 551

The following on-the-scene review of the Sixth Councilor District program was written by Dr. R. R. Fisher, chairman of the Postgraduate Day Committee, for the *Bulletin of the Mahoning County Medical Society*:

The Annual Sixth Councilor District Postgraduate Day was a resounding success. Although only 358 physicians registered prior to the meeting, some 551 attended the Assembly, the largest turnout in many years.

This unexpected attendance, although gratifying, was not without its problems. Originally scheduled for 325 meals, the final count, after much blood, sweat, and tears was 482 dinners served at the banquet.

Perhaps the greatest single reason for this unprecedented attendance was the remarkably fine program of speakers gathered by Dr. Craig Wallace and his committee. It would be impossible in this space to reiterate the list of outstanding speakers, but the quality of the program is attested to by the fact that the Ohio Academy of General Practice assigned us 7½ hours of Category II credit, more than was ever assigned to any of our meetings in the past. Even one of our speakers offered the statement that it was the largest undertaking he had ever seen at a district level.

The Woman's Auxiliary enjoyed a similar success with 165 women attending the luncheon to hear Mr. Warren Guthrie. The Social Committee headed by Mrs. George Cook and Mrs. Robert Fisher were up till the wee hours making extra name cards and table decorations for their swelling registration.

The banquet speaker was Dr. Douglas Bond, Professor of Psychiatry at Western Reserve University. Both the doctors and their wives enjoyed Dr. Bond's somewhat whimsical appraisal of the practicing physician, and his more serious plea that we all take a little more time to listen to our patients.

With the memory of an excellent meeting in Warren last year, and now another fine meeting in Youngstown, it appears that the annual Postgraduate Day has become established as a serious, scientific meeting which cannot be overlooked. We are looking forward with great anticipation to being in Canton on October 23, for Postgraduate—1957.

* * *

Eighth District Physicians Gather For Program at McConnelsville

A meeting of the Eighth Councilor District of the OSMA was held at Rocky Glen Sanatorium, McConnelsville, October 18, with approximately 75 physicians present. The program was arranged by the district officers: Dr. A. M. Kelly, Lancaster, president, and Dr. C. R. Reed, Lancaster, secretary.

Dr. Henry Bachman, Medical Director of Rocky Glen Sanatorium, spoke on "Recent Advances in Drug Therapy for Tuberculosis." Dr. Perry R. Ayres, Assistant Clinical Professor of Medicine, Ohio State University College of Medicine, discussed "Can Cardiacs Work?" Dr. A. L. Ke-fauver, Chief Deputy Medical Administrator, Bureau of Workmen's Compensation, Columbus, explained "The New Workmen's Compensation Law and How It Affects the Physician."

Col. Paul S. Fancher, M. C., Chief of the De-

partment of Medicine, Letterman Army Hospital, San Francisco, Cal., gave an address on "An Era in Military Medicine." In the course of his remarks, Col. Fancher, a native Ohioan, paid tribute to Col. E. C. Jones, M. C. ret., McConnellsville, for his long and distinguished service in the Medical Corps of the United States Army. Col. Fancher also read a letter of commendation to Col. Jones from Major General Silas B. Hays, Surgeon General of the Army.

The 50-year award and gold pin of the OSMA were then presented to Col. Jones by Dr. William D. Monger, Lancaster, Councilor for the Eighth District.

Robert Secrest, formerly Congressman for the 15th Ohio District and now a member of the Federal Trade Commission, explained some of the problems of the Commission in its efforts to "clean up" advertising of drugs, appliances, patent medicines, etc.

George H. Saville, Director of Public Relations, Ohio State Medical Association, talked on the activities of the Association.

The following new officers were elected: Dr. James T. Asch, Marietta, president, and Dr. N. M. LaBarre, Marietta, secretary.

The meeting concluded with a social hour and buffet supper, at which the Rocky Glen Sanatorium was host.

Springfield Class for Diabetics Near Two Years Operation

The Chronic Illness Newsletter of the American Medical Association reported as follows: "In Springfield, Ohio, diabetics are learning to live successfully and normally with their condition, through the help of group teaching classes being conducted by the City Department of Health. The classes were started in January, 1955, with the interest and support of physicians in the city, and consist of six two-hour sessions. . . . During the first year of operation, 79 persons with diabetes attended the sessions."

Iowa Hospital Dispute To Be Taken to Legislature

The hospital-specialist dispute in Iowa is to be taken to the Iowa legislature, according to the *Journal of the American Hospital Association*.

A Citizens Committee of Iowa Hospitals, led by hospital trustees, plans to seek the legislation when the legislature meets in January.

The Iowa attorney general ruled, in 1954, that any salary arrangements with specialists, other than lease, violated the Iowa Medical Practice Act. The case was taken into district court and the court found for the specialists. That finding is now on appeal.

In FUNCTIONAL UTERINE BLEEDING,¹ the authors report (on the basis of observation of more than 4,000 patients):

"Therapeutically, experience has shown that best results were obtained when the B complex prescribed was derived from Mammalian liver containing all the known as well as the yet unidentified factors of this group."

¹ Biskind, L. H., and Biskind, J. I.: MISSOURI MEDICINE: 53:843-848, (Oct.) 1956.

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*References and clinical trial supplies available on request.



In Memoriam . . .

Harold J. Abrams, M. D., Shaker Heights; University of Louisville School of Medicine, 1934; aged 49; died October 8; member of the Ohio State Medical Association. A native of the Cleveland area, Dr. Abrams served most of his professional career there. During World War II, Dr. Abrams was a captain in the Army Medical Corps and saw action in the Pacific. He was a member of the Ansel Road Temple. Survivors include his widow, a son and a sister.

Sigfried Baumoel, M. D., Cleveland; Western Reserve University School of Medicine, 1908; aged 72; died October 17; member of the Ohio State Medical Association and the American Medical Association; diplomate of the American Board of Psychiatry and Neurology. Dr. Baumoel practiced for many years in Cleveland where he helped found the Cleveland Neurological Society and where he was formerly head of the Neurological Department at Mt. Sinai Hospital. Surviving are a son, two daughters and three brothers.

Wallace J. Benner, M. D., Lakewood; University of Wooster Medical Department, Cleveland, 1903; former member of the Ohio State Medical Association and recipient of the OSMA 50-Year Award. Dr. Benner served his entire professional career in Lakewood where for 36 years he was health commissioner, and where in 1907 he helped found the Lakewood Hospital. Active in civic affairs, he was a past-president of the local Chamber of Commerce and the Kiwanis Club. A son survives.

Charles W. Bird, M. D., Columbus; Ohio Medical University, Columbus, 1900; aged 84; died October 19; former member of the Ohio State Medical Association; recipient of the 50-Year Pin and Certificate of the Ohio State Medical Association. After completion of his medical education, Dr. Bird moved to Continental in Putnam County and continued in practice until his retirement in 1954. He served many years on the county board of health and the school board and was a member of the Masonic Lodge and the Methodist Church. Surviving are his widow, two daughters, a son and two sisters.

Wells F. Horton, M. D., Eclectic Medical College, Cincinnati, 1893; aged 91; died October 6, in the Masonic Home in Springfield where he had been a resident since 1948. Dr. Horton began his practice in Cortland, but moved to the Cleveland area about 1910 and practiced in Lakewood, Rocky River and Bay Village. Two daughters survive.

Johnson S. Hunter, M. D., Jackson; College of Physicians and Surgeons of Baltimore, 1894; aged 91; died October 18; member of the Ohio State Medical Association and the American

Medical Association; recipient of the OSMA 50-Year Award. Dr. Hunter served his entire medical career in Jackson with the exception of a year in Piketon and time served with the Medical Corps during World War I. He was a member of the Methodist Church, the Rotary Club, Masonic Lodge, Moose and the American Legion. A daughter and a brother survive.

Leonard W. Kuttler, M. D., Willoughby; Ohio State University College of Homeopathic Medicine, Columbus, 1915; aged 72; died October 2. Dr. Kuttler practiced for about 40 years in the Lake County and East Cleveland area. For a number of years he operated the East End Hospital. Activities included memberships in several Masonic bodies. Survivors include his widow, a daughter and a son.

Harold K. Mouser, M. D., Coral Gables, Florida; Indiana Medical College, Purdue University, 1907; aged 72; died October 18; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of General Practice; past-president of the Marion County Academy of Medicine, and past-president of the Northwestern Ohio Medical Association. Dr. Mouser practiced for about 40 years in Marion before he retired five years ago and moved to Florida. During World War I, he served with the Army Medical Corps. In addition to his medical work, he was active in several local organizations; was a member of the Rotary Club and the Presbyterian Church. His widow survives.

John Will Payne, M. D., Springfield; Louisville Medical College, 1905; aged 84; died October 13; former member of the Ohio State Medical Association; received the OSMA 50-Year Award in 1955. A native of Lawrence County, Dr. Payne served most of his professional career there, where he was county and Ironton health commissioner for many years and served as county coroner. He moved to Springfield several years ago after retirement. Survivors include two daughters, two sons, two brothers and a sister.

Carl G. Rossel, M. D., Columbus; Ohio State University College of Medicine, 1931; aged 56; died October 25; member of the Ohio State Medical Association and the American Medical Association. Dr. Rossel graduated in dentistry from Ohio State in 1923 and practiced that profession in Zanesville for several years, later acquiring the M. D. degree. His medical practice was in Columbus. He was a member of the Ohio State Dental Association and other dental and medical organizations and several Masonic bodies. Survivors include his widow; two sons, one of whom is Dr. Charles W. Rossel of Columbus, and three brothers who are dentists, Dr. Roy M.

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Samuel Schwebel, M. D., Youngstown; Jefferson Medical College of Philadelphia, 1932; aged 49; died October 18; member of the Ohio State Medical Association, the American Medical Association and the American Academy of Dermatology and Syphilology; diplomate of the American Board of Dermatology and Syphilology. A native of Youngstown, Dr. Schwebel practiced there for about 25 years. He was a member of B'nai B'rith, the Jewish Federation, the Temple and the Elks Lodge. Survivors include his widow, his mother, three sisters and two brothers.

Justin C. Tay, M. D., East Cleveland; University of Vermont College of Medicine, 1920; aged 66; died October 8; member of the Ohio State Medical Association and the American Medical Association through 1955; Dr. Tay practiced in Vermont for a short time before he moved to East Cleveland. In addition to his practice, he was physician to the East Cleveland police and fire departments. Affiliations included memberships in the Exchange Club, the Elks, and several Masonic bodies. His widow survives.

Morris Wirtshafter, M. D., Cleveland; Maryland Medical College, 1911; aged 68; died October 22; former member of the Ohio State Medical Association, last in 1917. Dr. Wirtshafter had been a practicing physician in Cleveland for about 45 years. He is survived by his widow, two sons, a daughter, three sisters and two brothers.

Project Committee Will Gather Facts On Heart Disease in Ohio

A special Projects Committee to gather facts on Heart disease activities throughout Ohio has been appointed by the Ohio State Heart Association, according to Dr. Maurice A. Schnitker, Toledo, President.

Members of this committee, headed by Dr. Bernard A. Schwartz, Cincinnati, will gather facts on heart research, clinical activities, education and other types of activities in the cardiovascular field conducted not only by the Heart Associations but other groups as well.

Serving on this committee with Dr. Schwartz are: Drs. Charlotte Ames, Xenia; R. K. Bartholomew, Dayton; H. E. Baughman, Portsmouth; A. C. Corcoran, Cleveland; Harry Gauchat, Canton; Hugh B. Hull, Columbus; J. Lester Kobacker, Toledo; Simon Koletsky; Cleveland; Robert A. Lyon, Cincinnati; A. D. Robertson, Ashland; John A. Rogers, Youngstown; M. H. Rosenblum, Steubenville; Joseph M. Ryan, Columbus; A. B. Schneider, Cleveland; Clark D. West, Cincinnati.

Dr. Edwin H. Artman, Councilor of the OSMA Tenth District, addressed a recent meeting of the Chillicothe Rotary Club on the subject, "The Changing Face of Medicine."

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*Modell, W.: The Relief of Symptoms, Philadelphia, W. B. Saunders Company, 1955, pp. 265-266.

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Activities of County Societies . . .

First District

(COUNCILOR: FRANK H. MAYFIELD, M. D.,
CINCINNATI)

CLINTON

Dr. Robert Keith, assistant professor of surgery, Ohio State University, spoke at the October luncheon meeting of the Clinton County Medical Society, on the subject of diverticula of the colon and varicose veins.

Dr. Nathan S. Hale as chairman reported progress by the committee to devise an emergency call system for the public. Dr. Robert Conard, county health commissioner, urged doctors to continue the polio vaccine inoculations toward a complete coverage of children in the area.

Second District

(COUNCILOR: G. A. WOODHOUSE, M. D.,
PLEASANT HILL)

CLARK

Dr. M. A. Blankenhorn, professor emeritus of medicine at the University of Cincinnati College of Medicine, spoke on the subject, "Fever of Undetermined Origin," at the October meeting of the Clark County Medical Society.

Dr. Ray M. Turner has been re-elected as district trustee of the Ohio Division, American Cancer Society.—Robt. E. Teach.

MIAMI

"The Headache Problem" was the topic of discussion at the November 9 meeting of the Miami County Medical Society. The speaker was Dr. David Roth, of Dayton.

MONTGOMERY

Dr. G. C. Chiu, associated with the Lilly Research Laboratories, was guest speaker at the November 2 meeting of the Montgomery County Medical Society. He spoke on the subject, "Atherosclerosis and Its Therapeutic Approach."

Dr. Sidney Wolpaw, Cleveland, was guest speaker at the November 14 meeting of the Internal Medicine Section of the Montgomery County Medical Society. He discussed "Non-Tubercular Chest Lesions."

The Dayton Obstetrical and Gynecological Society met on October 17 in the Van Cleve Hotel for dinner and a program. Dr. Lester J. Bossert, professor of gynecology, University of Cincinnati, spoke on the subject, "Vaginal Hysterectomy."

The Dayton Surgical Society met on October 30 at the Van Cleve Hotel in Dayton. Dr. William A. Altemeier, professor of surgery at the University of Cincinnati, spoke on the topic, "The Current Concepts in Antibiotic Therapy."

Third District

(COUNCILOR: JAMES R. JARVIS, M. D., VAN WERT)

ALLEN

Dr. John M. Sheldon, director of graduate medicine at the University of Michigan, spoke to the Lima and Allen County Academy of Medicine on the subject of drug allergies. Some 88 members and guests attended the October 16 meeting at the Shawnee Country Club, Lima.

Fourth District

(COUNCILOR: PAUL F. ORR, M. D., PERRYSBURG)

LUCAS

Regular meetings in Toledo during October included the Postgraduate Lecture Series in which Dr. Kathleen E. Roberts and Dr. Parker Vanamee, of the New York Memorial Center, discussed "Electrolyte Alterations in Disease." The following section meetings were held:

Pathology Section: "Radio Isotopes — Basic Physics and Their Clinical Applications," Dr. Arthur J. Solari, University of Michigan.

Medical Section: "Current Concepts in Thyroid Diseases," Dr. Penn G. Skillern, Cleveland Clinic.

Surgical Section: "Symposium on Appendicitis"; Panel: Drs. F. P. Osgood (chairman), Richard Hotz, Edward Doermann, H. L. Hauman, Harold Shapiro and C. S. Wohl.

The November program included the following features:

General Section: "Behind the Scenes," Leo Brown, director of the AMA Public Relations Department.

General Practice Section: "Renal Pathology Associated with Normal Urine," Dr. A. S. Avery; and "Statistical Report on Salk Vaccine," Dr. W. G. Henry.

Medical Section: Panel Discussion on "Allergies," Drs. Henry Beale (moderator), Sam Friedmar, Karl Figley, Wallace Morton and Frank Rawling.

Surgical Section (not held because of Thanksgiving holidays).

Specialty Section: "Management of the Eclampsogenic Toxemias," Dr. Allan C. Barnes, professor and chairman of the Department of Obstetrics and Gynecology, Western Reserve University.

PUTNAM

October meeting of Putnam Society was held at Dumont Hotel, Ottawa, October 2. Guest speakers were Dr. Paul F. Orr, councilor Fourth District, and Dr. J. F. Holtzmuller, Health Commissioner for Putnam County.

Dr. Holtzmuller discussed the present polio

situation and the problems of migratory farm workers and their care.

Dr. Orr's address dealt mainly with legislative problems, including the recent law concerning care of Armed Service personnel and their dependents. He also discussed proposed legislation and its probable impact upon private practice.

During the evening a fifty-year pin was presented by Dr. Orr to Dr. J. R. Echelbarger, in recognition of his completion of fifty years of practice. Most of this fifty years Dr. Echelbarger has spent in Ottawa. He is in active general practice in Ottawa and is Coroner of Putnam County, an office he has held for a number of years.—H. N. Trumbull, M. D., Correspondent.

Fifth District

(COUNCILOR: GEORGE W. PETZNICK, M. D.,
CLEVELAND)

ASHTABULA

Members of the Ashtabula County Medical Society and their wives were guests of the Ashtabula County Bar Association for a dinner program on October 17. The principal speaker for the occasion was Judge Earl R. Hoover, of the Cuyahoga County Common Pleas Court. He denounced what he termed the negative approach to politics and urged citizens represented to take a positive interest in civic and political affairs.

Dr. C. J. Streicher, president of the Medical Society, spoke briefly, as did Carey S. Sheldon, president of the local Bar Association.

Sixth District

(COUNCILOR: CARL A. GUSTAFSON, M. D.,
YOUNGSTOWN)

MAHONING

Dr. Geo. J. Hamwi, chief of the Division of Endocrinology and Metabolism, Ohio State University College of Medicine, was guest speaker at the November 20 meeting of the Mahoning County Medical Society in the Elks Club, Youngstown. His subject was "Recent Advances in Diabetes Mellitus."

SUMMIT

The Summit County Medical Society and the Akron Area Rheumatism Society co-sponsored a program on November 6 on the subject "Diagnosis and Therapy in Rheumatic Diseases." The speaker was Dr. Edward F. Rosenberg, assistant professor of medicine, Chicago Medical School. Dinner was served in the Akron City Club and the evening meeting held in the Akron General Hospital Auditorium.

Seventh District

(COUNCILOR: ROBERT HOPKINS, M. D., COSHOCTON)

BELMONT

The Belmont County Medical Society met on November 15 at the Belmont Hills Country Club



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for dinner and a meeting. The program consisted of a discussion on civil defense by Dr. J. H. Carson.

Tenth District

(COUNCILOR: E. H. ARTMAN, M. D., CHILLICOTHE)

UNION

Two veteran physicians were honored at a banquet meeting of the Union County Medical Society in Marysville Memorial Hospital. They are Dr. H. G. Southard and Dr. W. H. Lee.

Dr. Edwin H. Artman, Chillicothe, Councilor of the Tenth District, presented each physician with the 50-Year Pin and Certificate of the Ohio State Medical Association.

Dr. Lee, a native of Vinton County, set up practice in Rockbridge following graduation from Ohio Medical College. After four years at Rockbridge, he moved to Plain City where he is still in practice.

Dr. Southard has had a distinguished career in the field of public health. He entered U. S. Public Health work during World War I, served for a number of years with the Ohio Department of Health, and later served 13 years as health commissioner of Athens and Vinton and Hocking Counties. He retired three years ago and moved to Marysville.

Eleventh District

(COUNCILOR: H. T. PEASE, M. D., WADSWORTH)

RICHLAND

Members of the Richland County Medical Society and their wives met October 18 for dinner and the program which followed. Eighty-four were in attendance.

The guest speaker on this occasion was Dr. Richard L. Meiling, Columbus, President of the Ohio State Medical Association. The subject of his address was "Physician Responsibility."—Harry Wain, M. D., chairman, Program Committee.

Lack of Caution on Part of Cyclists Blamed for Many Accidents

About 400 youngsters between the ages of 5 and 14 die each year as the result of bicycle accidents. Thousands more are injured. Many of these accidents would be eliminated if traffic regulations and safety rules were observed by cyclists, the Metropolitan Life Insurance Company reports.

These dangerous actions by cyclists are common factors in bicycle-motor vehicle collisions: Swerving into the path of a motor vehicle, coming out of a driveway without exercising caution, entering a traffic lane from behind a parked car, racing with other cyclists, riding in darkness without reflectors or lights, loss of control through carrying an extra passenger or through mechanical defect.

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Do You Know? . . .

Dr. Harvey C. Gunderson, of Toledo, was presented the Golden Head Mirror Honor Award of the American Rhinologic Society which met in Chicago.

* * *

Dr. George S. Hackett, Canton, appeared recently as guest speaker at the annual meeting of the New Brunswick Medical Association. His subject was "Low Back Ligament Disability, Referred Pain and Sciatica."

* * *

Dr. Roy L. Kile, Cincinnati, addressed the Iowa State Academy of General Practice at its recent meeting in Des Moines. His subject was "Newer Therapeutic Preparations in Dermatology."

* * *

Dr. Thomas M. Rivers, New York City, formerly vice-president of the Rockefeller Institute for Medical Research, has been appointed medical director of the National Foundation for Infantile Paralysis. He succeeds Dr. Hart E. Van Riper, who left the foundation to accept a position as medical director of Geigy Pharmaceuticals, Inc.

* * *

Dr. Marion A. Blankenhorn has been appointed to the position of director of education in the Department of Internal Medicine of the Jewish Hospital in Cincinnati. He recently retired as the Taylor Professor of Medicine and director of the Department of Internal Medicine in the College of Medicine, University of Cincinnati and director of medical service at Cincinnati General Hospital. He remains as professor emeritus at the College.

* * *

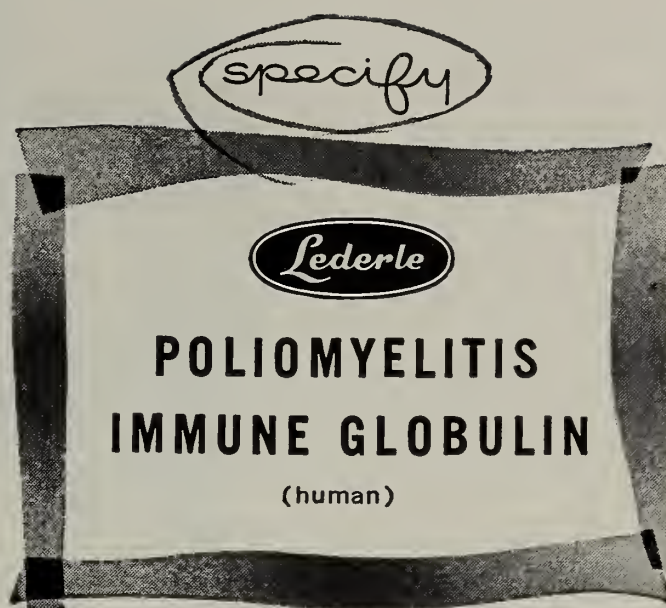
The American College of Chest Physicians has announced postgraduate courses as follows: Vanderbilt University, Nashville, Tenn., January 14-18; Mark Hopkins Hotel, San Francisco, Calif., February 25 - March 1; Bellevue-Stratford Hotel, Philadelphia, Pa., April 1-5.

* * *

Dr. James P. Hughes, Columbus, will leave Ohio about March 1 to assume his new duties as medical director of the Kaiser Aluminum & Chemical Corp., Oakland, Calif. Dr. Hughes is a member of the OSMA Committee on Industrial Health and Workmen's Compensation. He is chief physician and Medical consultant for the Columbus Employee Health Service and associate professor of preventive medicine at Ohio State University. He formerly was associated with the University of Cincinnati Health Department.

* * *

The Southwestern Ohio Society of General Physicians, a branch of the Ohio Academy of General Practitioners, sponsored four weekly seminars during October in collaboration with the University of Cincinnati College of Medicine.



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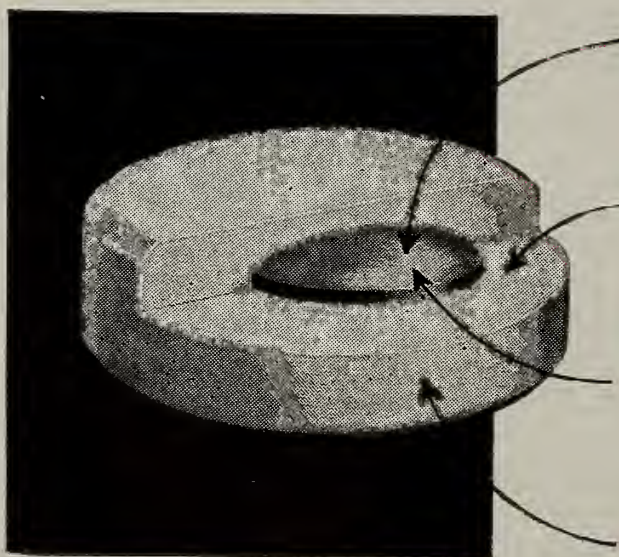
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President—Mrs. William H. Evans, 291 Park Ave., Youngstown

President-Elect—Mrs. V. R. Frederick, 145 Tanglewood Dr.,
Urbana

Vice-President: 1—Mrs. C. H. Bell, Mansfield
2—Mrs. W. R. Gibson, Oak Harbor
3—Mrs. C. A. Colombi, Cleveland

Recording Secretary—Mrs. Lester W. Sontag, Livermore St.,
Yellow Springs

Corresponding Secretary—Mrs. Earl Young, 170 Brookline
Ave., Youngstown

Past-President and Finance Chairman—Mrs. Karl Ritter,
1420 Shawnee Rd., Lima

Chairman Publicity Committee—Mrs. Carl F. Goll

BUTLER

The Woman's Auxiliary to the Butler County Medical Society was host to seven sister chapters in the state on Thursday, October 4, in the Hotel Manchester, Middletown. The state president, Mrs. William Evans, of Youngstown, and president-elect, Mrs. V. R. Frederick, of Urbana, conducted the workshops. Mrs. Muriel Allen, executive secretary of Senior Citizens, Inc., of Hamilton, was the guest speaker at the afternoon session.

COLUMBIANA

Three safety rules for drivers were cited by Patrolman James Patterson of the Salem Barracks of the State Highway Patrol at the meeting of the Woman's Auxiliary to the Columbiana Medical Society following the joint dinner with the medical group October 23 at Lisbon.

Reports of chairmen were heard during business conducted by Mrs. William J. Horger, president. She urged members to cooperate with Senior Citizens and Golden Age groups and give aid to older people by visitation, cards and gifts. This project will be conducted by Mrs. Janis Lauva of Wellsville as a mental health committee activity.

Plans were discussed for a Doctor's Day observance in December. Members were reminded that Auxiliary handbooks are available through Mrs. K. W. Turner. Mrs. J. S. Jones and Mrs. Wade Bacon of Lisbon were hostesses for this session at the Wick Hotel. Mrs. Charles A. Gerace, safety chairman, was in charge of the program.

FAIRFIELD

The Woman's Auxiliary to the Fairfield County Medical Society entertained the Eighth District members at their annual meeting October 5 at Lancaster Country Club. Luncheon, served to 43 members, preceded the business meeting.

Mrs. C. R. Reed, county Auxiliary president, introduced Mrs. Frederick W. James, district director, who welcomed these state officers: Mrs. William Evans, of Youngstown, State President; Mrs. C. H. Bell, Mansfield, first vice-president; Mrs. Myron Thomas, Garrettsville, state chair-

man of members-at-large; Mrs. Galon Rodabaugh, state nurses recruitment chairman; Mrs. Chester P. Swett, state nurses' loan fund chairman. These counties had representatives at the meeting; Licking, Muskingum, Guernsey, and Fairfield.

Frank S. Benson of the The Hickle Co., assisted by Mrs. Hope Kost, presented a trunk showing of a fall line of jersey separates.

FRANKLIN

Dr. Ollie M. Goodloe, assisted by Mrs. George M. Curtis, spoke on health services in the community at a meeting October 15 of the Woman's Auxiliary to Columbus Academy of Medicine.

Dr. Goodloe, health commissioner of Columbus, discussed the topic, "Does Your Vote Affect Health Services in the Community?" Mrs. Curtis, chairman of the legislative committee of the Academy Auxiliary gave a short talk on this subject also.

GREENE

The Auxiliary to the Greene County Medical Society held its regular meeting with Mrs. A. C. Messenger October 12. Seventeen members were present.

Dr. Paul D. Espey, chairman of the legislative committee of the Greene County Medical Association, spoke on "Pertinent Medical Legislation for Greene County." He particularly stressed the need for an added wing at Greene Memorial Hospital in the near future, pending school legislation, and the levy to hospitalize infectious tuberculosis cases.

In conjunction with the Shawnee Parent Teachers Association, this Auxiliary sponsored a lecture by Dr. Harry DeWire on October 18. He spoke on "Living With Your Tensions." Mrs. Harold Ray, mental health chairman of the Auxiliary, was in charge of the program.

HARDIN

Mrs. A. W. Sage, who, with her husband, Dr. A. W. Sage, will mark their golden wedding anniversary on December 24, was honored by members of the Hardin County Medical Auxiliary on Tuesday, October 9. Mrs. Sage, charter member, ardent worker and third president of the Auxiliary, entertained the group with interesting highlights of her 50 years as wife of a physician.

Mrs. Floyd Elliott was in charge of the business session at which time 22 members responded to roll call.

Tentative plans for the annual Mistletoe Ball were discussed and the date announced for Friday, December 28.

JEFFERSON

The opening fall luncheon meeting of the Jefferson County Medical Society was held October 19 in the home of Mrs. John Mantica. Mrs.

W. M. Everhard, seventh district director, was a guest.

It was reported that a new student nurse is using an Auxiliary scholarship. Another Auxiliary-sponsored student, JoAnn Fithen, who is studying in Wheeling, W. Va., has been elected president of the West Virginia Student Nurses' Association.

HURON

Mrs. Elton Hoyt, a member of the Huron County Council for Retarded Children, was the guest speaker of the October meeting of the Woman's Auxiliary to the Huron County Medical Society, which met with Mrs. G. F. Linn of Norwalk.

Mrs. Hoyt explained the necessity for bringing the work with retarded children to the attention of every person in Huron County. The schools, being organized for these children, render an important service depending upon the I. Q. of the children and their physical handicaps.

KNOX

Mrs. A. S. Mack entertained members of the Woman's Auxiliary to the Knox County Medical Society October 17.

A short talk on school and city tax levies was given by Mrs. Grant Woodward.

LUCAS

The Woman's Auxiliary to the Academy of Medicine of Toledo and Lucas County met on October 9 in the Medical Academy Building. The 162 members in attendance enjoyed a book review on *The Great Rehearsal* presented by Mrs. Paul Alexander. In addition revisions of the constitution and by-laws of the Auxiliary were presented and year books were distributed.

All of the Study Groups were organized in October and the respective groups met. The following are now active as study groups: The Gourmet Group, headed by Mrs. C. J. A. Paule, Mrs. Robert Kriess and Mrs. Ira Winger; The Live Issues Group, under Mrs. A. P. R. James; Home Decoration and Gardening, under Mrs. Fred Clement; The Bridge Group, led by Mrs. Morris Selman; and the Musical Masqueraders, led by Mrs. Eugene Ockuly and Mrs. Jack Minns.

MIAMI

The Woman's Auxiliary to the Miami County Medical Society met on October 2 at Dettmer General Hospital for a luncheon meeting.

Featured on the program was a talk by Lt. William Harrison of the Ohio State Highway patrol. The business meeting was conducted by Mrs. E. G. Puterbaugh.

MARION

Members of the Auxiliary to the Marion Academy of Medicine approved a donation to United Appeals when they met October 16. The meeting

(Continued on Page 1362)

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HAVE PROLONGED

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AND LIFE SPAN OF

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FROM CONGESTIVE

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*Fishberg, A. M.: Hypertension and Nephritis, ed. 5, Philadelphia, Lea & Febiger, 1954, pp. 177-178.

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STARTING DATES—WINTER, 1956-1957

SURGERY—Surgical Technic, two weeks, Dec. 10, Jan. 28. Surgery of Colon & Rectum, one week, Mar. 4. General Surgery, one week, Feb. 11. General Surgery, two weeks, Apr. 23. Surgical Anatomy & Clinical Surgery, two weeks, Mar. 4. Surgical Pathology, 2 or 4 weeks, by appointment. Basic Principles in General Surgery, two weeks, Jan. 14. Fractures & Traumatic Surgery, two weeks, Mar. 11. Anesthesia, 2 or 4 weeks, by appointment.

GYNECOLOGY & OBSTETRICS—Office & Operative Gynecology, two weeks, Feb. 11. Vaginal Approach to Pelvic Surgery, one week, Feb. 4. General & Surgical Obstetrics, two weeks, Feb. 25.

MEDICINE—Electrocardiography & Heart Disease, two-week basic course, Mar. 11. Gastroenterology, two weeks, May 13. Dermatology, two weeks, May 6. Gastroscopy, two weeks, Mar. 18.

RADIOLOGY—Diagnostic X-Ray, two weeks, Feb. 4. Clinical Uses of Radioisotopes, two weeks, May 6.

UROLOGY—Two-Week Course Apr. 1. Cystoscopy, ten days, by appointment.

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was in form of a tea in the home of Mrs. William Leffler.

Mrs. J. A. McNamara and Mrs. Paul Lyons discussed at length the project of making a loan available to future nurses for financial assistance to continue their studies. It was voted to sponsor a benefit bridge to raise money for providing the loans.

OTTAWA

The Woman's Auxiliary to the Ottawa County Medical Society met at the home of Dr. and Mrs. D. F. Loeffler, October 11. The president, Mrs. Cyrus Wood conducted the business meeting. Final plans for the annual rummage sale were made. Mrs. Jack Witker, program chairman submitted the program outline for the year. Mrs. James Rhiel gave a report on the role of animals in medical research from an article in *Today's Health* magazine.

RICHLAND

Dr. Harry Wain, city-county health commissioner, spoke on "Rural Health" at a luncheon meeting of the Woman's Auxiliary to the Richland County Medical Society on October 1. Forty members were present and Mrs. Raymond Stephens was a guest.

The business session was conducted by the president, Mrs. F. M. Wadsworth.

SUMMIT

The Woman's Auxiliary to the Summit County Medical Society held its regular monthly meeting at Congress Lake Country Club on October 2.

The Fourth Annual Benefit for the Revolving Loan Fund for Student Nurses was, once again, a big success. Mrs. Simon Schlueter is chairman of Ways and Means this year.

Mrs. Devitt Gordon, chairman of the Hobby Show, reported 120 entrants this year. The Senior Citizens of Summit County spent many happy hours, thanks to this Auxiliary.

Mary Cacioppo spoke on "Juvenile Delinquency" and a discussion on a new juvenile court center and detention home followed.

Guests included members of the Dental Society Auxiliary.

TUSCARAWAS

The Woman's Auxiliary to the Tuscarawas County Medical Society was the hostess group for the annual fall meeting of the Seventh District. The meeting was held on October 26 at the Union Country Club in Dover.

Mrs. M. W. Everhart of New Philadelphia, the District Director, introduced the following state officers: Mrs. William H. Evans of Youngstown, state president; Mrs. C. A. Colombi of Cleveland, third vice-president; Mrs. H. F. Van Epps of Dover, state treasurer; Mrs. Carl F. Goll, state publicity chairman; Mrs. M. W. Thomas, Garrets-

ville, member-at-large chairman; and Mrs. C. W. Kirkland, Bellaire, past state president.

The speaker for the afternoon was Mrs. Evans, who discussed the importance of voting; support of the American Medical Education Fund, and the giving of time and efforts to Civilian Defense work and mental health projects.

Mrs. Benjamin Pilloff of Uhrichsville, the Tuscarawas County Auxiliary president, told of interesting programs to be conducted in the future in the interests of public relations, health and civilian defense.

Center for Aging Research Established by USPHS

Establishment of a Center for Aging Research in the National Institutes of Health has been announced by Dr. Leroy E. Burney, Surgeon General of the Public Health Service, Department of Health, Education, and Welfare.

Dr. G. Halsey Hunt, at present associate chief of the Service's Bureau of Medical Services, has been appointed director of the Center.

Marion B. Folsom, Secretary of Health, Education, and Welfare, said: "I am hopeful that this new effort will help bring answers to some of the most critical and challenging health problems of our times. There are more than twelve million people in this country today who are over the age of 65; by 1970, there will be more than 18 million. Many of our older citizens have special health problems. It is important that more be done to help solve these problems—to help older persons to greater independence and self-sufficiency and a life more free of disease and disability."

The new Center is a part of the Public Health Service's program to coordinate and accelerate all of its activities in the field of aging. In the Office of the Surgeon General, these activities have been placed under the direction of Dr. John W. Porterfield, who resigned recently as director of the Ohio Department of Mental Hygiene and Correction to accept the post as assistant surgeon general of the USPHS.

Nutrition Meeting To Be Held In Southern Clime

Ohio physicians who wish to combine a trip South with a program on nutrition may do so in March. The American Medical Association Council on Foods and Nutrition is jointly sponsoring a program on "Fats in Human Nutrition" in New Orleans with the local medical society, the New Orleans Graduate Medical Assembly, and the Schools of Medicine of Louisiana State and Tulane Universities. Additional information may be obtained from the AMA Council on Foods and Nutrition.

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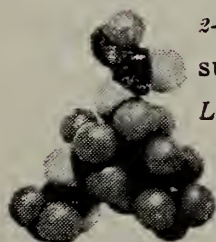
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Types of Deaths Reportable to Coroner...

A Summary of Provisions of the General Code Indicating When the Physician or Other Person Should Report to the Coroner's Office

THE following article, reprinted from The Bulletin of the Academy of Medicine of Cleveland, gives an excellent summary and interpretation of provisions of the Ohio General Code in regard to types of deaths which are reportable to the coroner's office. The article was prepared in the office of the Cuyahoga County coroner, under direction of Dr. Samuel R. Gerber.

* * *

This information has been compiled for the purpose of acquainting individuals and organizations with the procedures to be followed when they come in contact with the types of deaths described in the following pages.

Conformity with these procedures will prevent unnecessary delay and inconvenience to the family, friends, and those persons having any responsibility to and for the deceased.

Section 313.11 Revised Code (2855-12 General Code) Notification in Case of Death by Violence or Suicide.—Any person who discovers the body or acquires the first knowledge of the death of any person who died as a result of criminal or other violent means, or by casualty, or by suicide, or suddenly when in apparent health, or in any suspicious or unusual manner, shall immediately notify the office of the coroner of the known facts concerning the time, place, manner, and circumstances of such death, and of any other information which is required by sections 313.01 to 313.22, inclusive of the Revised Code.

In such cases, if request for cremation is made, the funeral director called in attendance, shall notify the coroner immediately. No person shall wilfully refuse to report such a death, or shall, without an order from the coroner, wilfully touch, remove, disturb the body of any such person, or disturb the clothing or any article upon or near such body.

Section 313.12 R. C. (2855-5 G. C.) Notification by Physician in Case of Death by Violence or Suicide.—When any person dies as a result of criminal or other violent means, or by casualty, or by suicide, or suddenly when in apparent health, or in any suspicious or unusual manner, the physician called in attendance shall immediately notify the office of the coroner of the known facts concerning the time, place, manner, and circumstances of such death, and any other information which is required pursuant to sections 313.01 to 313.12, inclusive of the Revised Code. In such cases, if a request is made for cremation,

the funeral director called in attendance shall immediately notify the coroner.

Section 313.99 Penalties.—(A) Whoever violates section 313.11 of the Revised Code shall be fined not less than one hundred nor more than five hundred dollars.

Section 1713.42 R. C. (12691 G. C.) Prohibition Against Unlawful Possession of Corpse.—No person shall be in possession of a corpse for the purpose of medical, surgical, or anatomical study, except as provided by law.

Section 2917.41 R. C. (12869 G. C.) Suppression of Evidence When Body Bears Marks of Violence.—No person shall receive a human body having on it marks of violence, at a medical college, medical society, school of anatomy, or other place, without giving notice forthwith to the coroner of the county wherein such body is then located.

Whoever violates this section shall be fined not less than five hundred nor more than one thousand dollars and imprisoned not less than one or more than ten years.

The coroner, upon receipt of such notice, shall hold an inquest.

Section 2923.09 R. C. (13392 G. C.) Anatomical Demonstration Upon a Corpse.—No person shall assist in a surgical operation or anatomical experiment or demonstration upon a corpse, knowing it to have been unlawfully obtained.

Whoever violates this section shall be fined not less than one hundred nor more than one thousand dollars or imprisoned not less than six months nor more than one year, or both.

I. Accidental Deaths:

All forms including death arising from employment.

1. Anesthetic Accident. (Death on the operating table or prior to recovery from anesthesia.)

2. Blows or other forms of mechanical violence.

3. Burns.

4. Crushed beneath falling objects.

5. Cutting or stabbing.

6. Drowning (Actual or suspected).

7. Electric shock.

8. Explosion.

9. Exposure.

10. Firearms.

11. Fractures of bones (not pathological). Such cases to be reported even when fracture is not primarily responsible for death.

12. Falls.

13. Carbon Monoxide Poisoning (Resulting

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15. Heat Exhaustion.
16. Insolation (Sunstroke).
17. Poisoning. (Food poisoning, occupational or other.)
18. Strangulation.
19. Suffocation. (Foreign object in bronchi, by bed clothing or other means.)
20. Vehicular Accidents. (Automobile, street-car, bus, railroad, motorcycle, bicycle or other.)

II. Homicidal Deaths.

III. Suicidal Deaths.

IV. Abortions — Criminal or Self-Induced. — When the manner of death falls within the above classification, such a death must be reported to the coroner even though the survival period subsequent to onset is 12 months.

V. Sudden Deaths:

When in apparent health or in any suspicious or unusual manner including:

1. Alcoholism.
2. Sudden death on the street, at home, in a public place, at place of employment.
3. Deaths under unknown circumstances, whenever there are no witnesses or where little or no information can be elicited concerning the deceased person. Deaths of this type include those persons whose dead bodies are found in the open, in places of temporary shelter, or in their home under conditions which offer no clues as to the cause of death.
4. Deaths which follow injuries sustained at place of employment whenever the circumstances surrounding such injury may ultimately be the subject of investigation. Deaths of this classification include:

Caisson Disease. (Bends.)

Industrial infections (Anthrax, septicemia following wounds including gas bacillus infections, tetanus, etc.).

Silicosis.

Industrial Poisonings (acids, alkalies, aniline, benzene, carbon monoxide, carbon tetrachloride, cyanogen, lead, nitrous fumes, etc.).

Contusions, abrasions, fractures, burns (flame, chemical or electrical) received during employment which in the opinion of the attending physician are sufficiently import, either as the cause or contributing factor to the cause of death, to warrant certifying them on the death certificate.

5. All stillborn infants where there is suspicion of illegal interference.

6. Death of persons where the attending physician cannot be found, or deaths of persons who have not been attended by a physician within two weeks prior to the date of death.

7. All deaths occurring within 24 hours of

admission to a hospital unless the patient has been under continuous care of a physician for a natural disease which is responsible for death.

To Report Death:

Call Coroner's office. Ask name of person to whom you are reporting.

To facilitate efficiency in processing cases, it is requested that the following information be submitted when reporting any death to the Coroner's Office.

1. Name and address of the deceased.
2. Age.
3. Married, single, widowed or divorced.
4. Color.
5. Time of accident or onset of cause of death. (Hour of day and date.)
6. Place, mode and manner where injury was sustained.
7. Place of death.
8. Time of death. (Hour of day and date.)
9. Location of body.
10. Other pertinent data.
11. Name of person reporting case. Date and time of reporting.
12. Name of physician who pronounced person dead.

Launch Study To Determine Services Hospitalized Patients Get

The American Medical Association is launching a study to learn what the hospital patient gets for his money.

It is the second phase of a three-part, five-year study measuring the medical services given to the American people by their physicians. The survey, which will cost about \$100,000 when completed, is the first of its kind—measuring services and not money spent.

The results, which will be published late in 1958, may help bring about changes in hospital construction, medical education, health insurance rates, and other health care matters.

Questionnaires have been mailed to 7,000 hospitals to learn the age, sex, length of stay, and diagnoses for every hospitalized person discharged during the third week of October.

In the first phase conducted in 1953, the AMA Bureau of Medical Economic Research determined the age and sex of hospital patients on a given day, and found that men were more hospitalized than women, even though one out of six beds was used for a maternity case. The final phase will be conducted next spring when physicians will contribute information about patients seen in the office and at home.

The current questionnaire will help answer such questions as: Which ailments or conditions are sending most Americans to hospitals? Which are keeping them there the longest? How many beds are taken up by accident casualties, by pregnant women, by patients undergoing non-emergency surgery?



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Attorney General's Opinion as to Inspection of Premises

Following is the syllabus of a recent opinion given by Attorney General C. William O'Neill:

"The health commissioner and other employees appointed by the board of health of a general health district are authorized at reasonable hours and in reasonable circumstances to enter private premises and to inspect the same to determine whether contagious disease or nuisances dangerous to public health exist therein but where the person lawfully in occupancy of such premises withholds his assent thereto such right of entry and inspection can be exercised only under authority of a search warrant issued by a judicial officer as provided by law except in those cases where (1) an immediate major crisis exists where there is neither time nor opportunity to apply to a magistrate, or (2) the premises involved are those on which the occupant carries on an activity licensed by such board of health."—Opinion No. 7172.

Fort Steuben Academy Announces Coming Features of Program

The Fort Steuben Academy of Medicine has announced subjects and speakers for its monthly meetings through May, 1957. Meetings are held in the Fort Steuben Hotel in Steubenville. On November 13, Dr. Karl P. Klassen, professor of thoracic surgery, Ohio State University, spoke on "The Present Status of Valvular Cardiac Surgery." Coming subjects and speakers have been announced as follows:

December 11—Dr. Garfield G. Duncan, "Management of Essential Hypertension."

January 8—Dr. Jack D. Myers, "Current Thoughts on Constructive Pericarditis."

February 12—Dr. Jack J. Rheingold, "RH Factor and Obstetrical Implications."

March 12—Dr. Waltman Walters, "Diagnosis and Management of Biliary Tract Disease."

April 9—Dr. Alton Ochsner, "Venous Thrombosis."

May 14—Dr. Richard B. Cattell, "Recent Changes in the Treatment of Carcinoma of the Large Bowel."

Physicians Asked To Be on Lookout For Missing Radium

Recently discovery was made of the absence of 70 mgs. of radium from the Good Samaritan Hospital in Dayton. A small portable lead carrier was also found missing and it appeared evident that the product had been taken by someone who is familiar with its use and hazards.

Physicians and hospitals are requested to be on the lookout because attempts may be made to market product.



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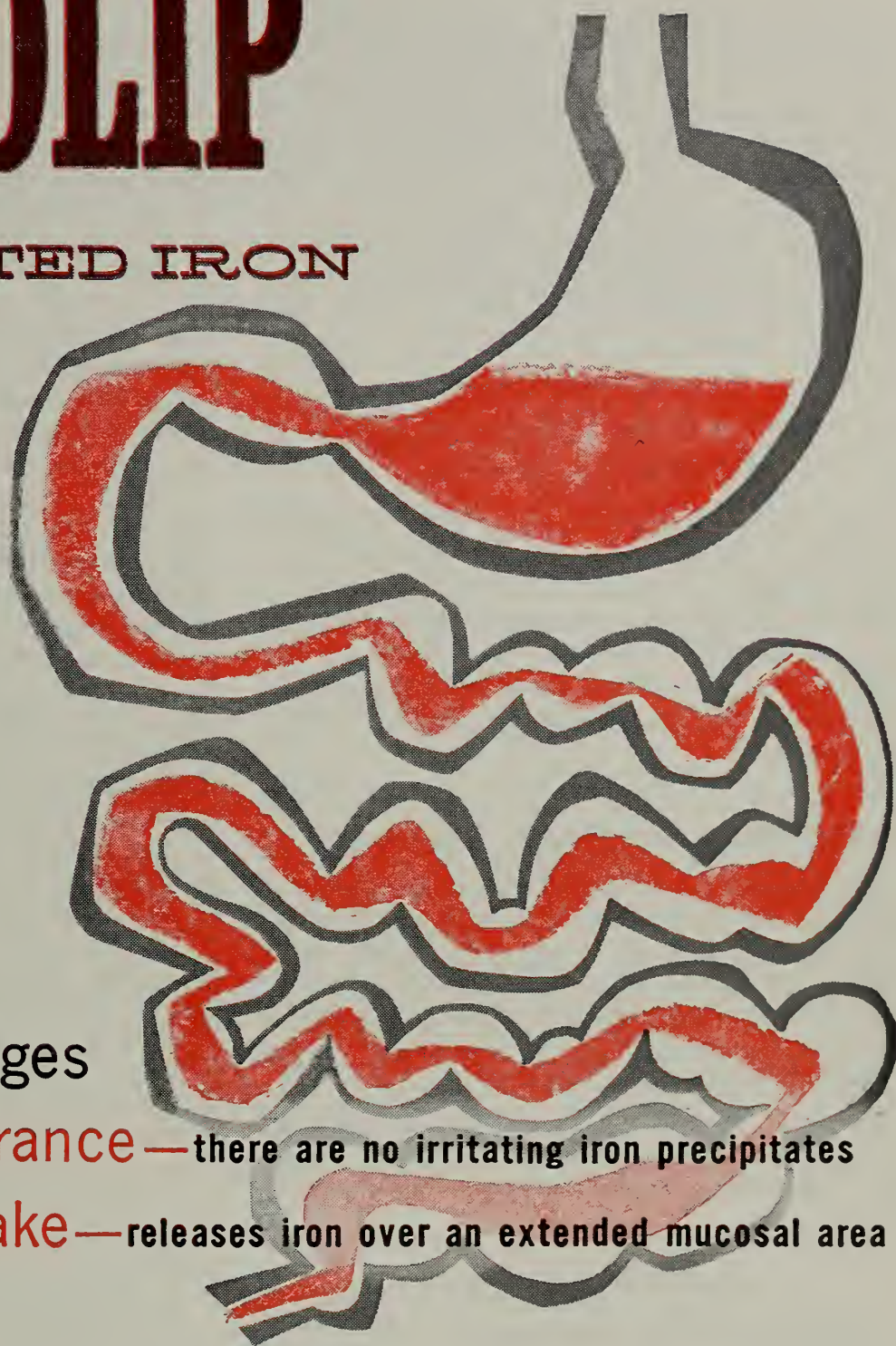
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Lakewood Participates in Drug Reaction Study

Lakewood Hospital is one of 11 hospitals of the nation cooperating in a study sponsored by the U. S. Food and Drug Administration to obtain data on adverse reactions of drugs which may appear in some patients when they are administered to large numbers of people. Collaborating in the study are the American Association of Medical Record Librarians, the American Society of Hospital Pharmacists, the American Medical Association and the American Hospital Association.

Beware Your Friends Bearing Firearms, Is Warning

Some 2,200 lives are lost yearly in the United States in firearm accidents as a result of hunting mishaps. In one study, three-fifths of hunters who lost their lives were killed by weapons of members of their own hunting party. Firearm accidents in and about the home actually account for far more fatalities than hunting.—Metropolitan.

Cincinnati Area General Physicians

A seminar on obstetrical and gynecological problems was held on November 25 at the Medical School Auditorium in Cincinnati under sponsorship of the Southwestern Ohio Society of General Physicians, the Cincinnati Obstetrical & Gynecological Society and the University of Cincinnati College of Medicine.

The next SOS of GP sponsored seminar topic will be "Trauma" and will be discussed on Sunday, January 20, at the Hartwell Country Club.

COMING MEETINGS

Ohio State Medical Association Annual Meeting, Columbus, May 14-16, 1957.

Academy of Medicine of Cincinnati, Centennial Exposition, Cincinnati Music Hall, February 27 - March 5.

American Medical Association, 1957 Annual Meeting, New York City, June 3 - 7.

Chicago Medical Society, Annual Clinical Conference, Palmer House, Chicago, March 5 - 7.

Merrell Symposium on Cardiovascular Disorders in the Aged, Netherland Hilton Hotel, Cincinnati, January 17.

National Health Forum, Hotel Hilton Plaza, Cincinnati, March 20 - 22.

Ohio Valley Proctologic Society, Quarterly Meeting, Cincinnati, January 11-12.

INDEX TO ADVERTISERS

Abbott Laboratories	1276-1277
American Medical Education Foundation	1286
Ames Company, Inc.	1365
Ann Arbor School	1270
Appalachian Hall	1284
Atlas Pharmaceutical Laboratories	1262
Ayerst Laboratories, Inc.	1354
Burroughs Wellcome & Co. (U. S. A.) Inc.	1255, 1366, 1367
Chicago Medical Society	1347
Ciba Pharmaceutical Products, Inc.	1288
Coca-Cola Company	1262
Columbus Pharmacal Company	1351
Cook County Graduate School of Medicine	1359
Corn Products Sales Co. (Karo)	1279
Davies, Rose & Co., Ltd.	1368
Desitin Chemical Company	1278
Ethicon, Inc.	1349
Flint, Eaton & Company	1369
Foot-so-Port Shoe Company	1270
Harding Sanitarium	1280
Hoffmann-LaRoche, Inc.	Insert between pages 1332 - 1333
Lakeside Laboratories, Inc.	1253, 1350, 1359
Lederle Laboratories	1273, 1324-1325, 1355
Lilly, Eli, and Company	1292
Luzier's, Inc.	1274
Magnetic Springs Foundation	1288
Mallard, Inc.	1353
McMillen Sanitarium	1280
Medical Protective Company	1355
Merck Sharp & Dohme	1260 - 1261 1269, 1285, 1356-1357
Merrell, The Wm. S., Company	1343
New York Polyclinic Medical School	1272
Parke, Davis & Company, ...	1360-1361, 1380 and Inside Back Cover
Pfizer, Chas. & Co., Inc., ...	1264-1265, 1271, 1290-1291
Quincy X-Ray & Radium Lab.	1371
Rawl Chemical Company	1346
Riker Laboratories, Inc.	1257
Rocky Glen Sanatorium	1274
Sanborn Company	1263
Sawyer Sanatorium	1275
Schering Corporation	1282 - 1283
Scroggins, Clayton L., Associates (Medical-Dental Management)	1286
Searle, G. D. & Company	1341
Smith, Kline & French Laboratories	1281 and Back Cover
Stoneman Press	1284
Tutag, S. J. & Company	1272
Upjohn Company	1289
U. S. Vitamin Corporation	1258 - 1259
Wallace Laboratories	1363
Wendt-Bristol Company	1350
Wickhaven Sanitarium	1274
Windsor Hospital, Inc.	1274
Winthrop Laboratories	1287, 1347

Classified Advertisements

Rates: 50 cents per line. Minimum charge of \$1.00 for each insertion. Prices cover the cost of remailing answers. Forms close 15th of the month preceding publication. To assure prompt delivery, when replying to an advertisement over a *Journal* box number, address letters as follows: Box (insert number), c/o The Ohio State Medical Journal, 79 East State St., Columbus 15, Ohio.

Physicians seeking locations in Ohio are invited to contact the Physicians' Placement Service in the executive offices of the Ohio State Medical Association, 79 E. State St., Columbus 15. Through this medium efforts are made to establish communications between physicians seeking locations and communities where physicians are needed, or other physicians who are in need of associates.

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FOR SALE: Portable Westinghouse 3KVA X-Ray; cassettes, Bucky diaphragm, illuminator, dark room light and timer; frames, fluoroscope, developing tank, examining table, office equipment, etc. M. H. Wenzinger, Exec., New Bavaria, Ohio.

GENERAL PRACTITIONER WANTED: Opening with established physician in southwestern Ohio. Write Box 900, c/o Ohio State Medical Journal.

Proctology Meeting Scheduled In Cincinnati

The next quarterly meeting of the Ohio Valley Proctologic Society will be held in Cincinnati, Friday and Saturday, January 11 and 12.

Hospital Surgical Clinics, Banquet and Addresses will be held on January 11. Hospital rounds, addresses and buffet luncheon will be held on January 12. Members of the profession and their wives may attend. Registration fee per person is \$10.

Additional information may be obtained from the secretary, A. Gerson Carmel, M. D., 214 Doctors Bldg., 19 Garfield Place, Cincinnati 2.

The American Urological Association, 1120 N. Charles St., Baltimore, Md., offers an annual award of \$1000 (first prize of \$500, second prize \$300 and third prize \$200) for essays on the result of some clinical or laboratory research in Urology. Competition is limited to urologists who have been graduated not more than 10 years, and to hospital interns and residents doing research work in urology.

FOR SALE: Fisher X-Ray & Fluoroscope, 88,000 volts, 60 ma., built-in Bucky; 12 yrs. old; A-1 condition; \$500. Also Fisher Diathermy, good condition, \$100. F. R. Ford, M. D., Gallipolis State Institute, Gallipolis, Ohio.

WANTED: Physician for locum tenens in an industrial office. 200 Republic Bldg., Cleveland 15, Ohio.

DUE TO ILLNESS am planning to give up well-established general medical practice on the west side of Cleveland in center of business district. Practice consists of general medicine, minor surgery and obstetrics. Will help successor take over. Completely equipped office. Terms or cash. Call for appointment, PROspect 1-3650, Cleveland, from 11 A. M. to 12 noon except Wednesday, or write Dr. E. M., Room 817, 2012 W. 25th St., Cleveland 13, Ohio.

FOR SALE: Practice, complete new office equipment and furniture of recently deceased Dermatologist, including modern "Treatmaster Special" x-ray therapy unit, Bovie Electrosurgical unit, Mill-Bilt planing unit, etc. Box 906, c/o Ohio State Medical Journal.

ASSISTANT WANTED by general practitioner and surgeon in small community near Columbus. Good hospital facilities. Write Box 905, c/o Ohio State Medical Journal.

GENERAL PRACTITIONER WANTED: Excellent opportunity in West-side Cleveland Suburb. New air-conditioned office with two medical and two dental suites. One medical suite is still available and contains nurses office, consultation room, two examining rooms and laboratory. Physician occupying the other medical suite has been doing general practice in the area for past six years and desires associate with similar interest. Write Box 907, c/o Ohio State Medical Journal.

PHYSICIAN, Ohio license, many years experience in general practice and ear, nose and throat, desires (at once) association with established individual, group or clinic. Box 908, c/o Ohio State Medical Journal.

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PHYSICIAN WANTED to take over established general practice in county seat city in central Ohio. I am retiring. Box 904, c/o The Ohio State Medical Journal.

FOR SALE: Time-Master Dictaphone, for dictating and transcribing; bought Sept. 1955 and hardly used; also Kellakett X-Ray for fluoroscopy and x-ray; little used. Joseph D. Kiener, M. D., 3337 E. Main St., Columbus, Ohio; Phone BELmont 5-6621.

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THE OHIO STATE MEDICAL JOURNAL

INDEX TO VOLUME 52—1956

January	Pages 1 to 108
February	" 109 to 220
March	" 221 to 340
April	" 341 to 456
May	" 457 to 556
June	" 557 to 684
July	" 685 to 792
August	" 793 to 896
September	" 897 to 1004
October	" 1005 to 1132
November	" 1133 to 1252
December	" 1253 to 1380

CLINICAL PAPERS

Acne Cleanser, An Improved (Benjamin Levine)	937	Carcinoma of the Lung, The Present Status of (Earle B. Kay and Frederick S. Cross)	249
Adenoidectomy, Postnasal Saline Pack Following (H. M. Amstutz)	164	Carcinoma, Primary, of the Fallopian Tube (Reid P. Joyce)	944
Adolescent Drug User, Toward Understanding the (William E. Todd and Ross M. Bleak)	821	Case Report Books, 1837, of the Commercial Hospital and Lunatic Asylum of the State of Ohio, Some Excerpts from (Leon Goldman)	601
Allergies as Causes of Middle Ear Effusion (Robert E. Boswell)	374	Central Nervous System Influence in the Genesis of Atrial Fibrillation (Jack Marks)	1054
Allergy, Bacterial—A Review (Hermann Blatt)	1293	Cerebral Angiography, Indications and Technique of (Curwood R. Hunter)	264
Amniotic Fluid Embolism, Presumed, with Recovery (Jack A. Pritchard and Robert J. Dugan)	379	Cervix, Carcinoma of the, Some Urological Aspects of: A Review of Recent Literature (John C. Buckingham and Jack N. Taylor)	255
Ambulation, The Achievement of, in Psychiatric Patients (Janice A. Mendelson)	25	Chemotherapeutic, Dermatological, An Appraisal of Piromen® as a (Ashton L. Welsh and Mitchell Ede)	148
Angina Decubitus: A Clinical Appreciation (John S. Watson)	581	Children's Cardiac Diagnostic Centers (Robert A. Lyon)	1050
Angiography, Cerebral, Indications and Technique of (Curwood R. Hunter)	264	Clinicopathological Conference:	
Arthritis, Rheumatoid, Prednisone and Prednisolone Therapy in: A Gastrointestinal Hazard? (Norman O. Rothermich and Vol K. Philips)	942	Aneurism of the Hepatic Artery	45
Arthritis, Treatment of, Evaluation of Combined Prednisolone-Aspirin Therapy in the (M. M. Szucs; Vitalij Holonko; K. M. Forster, and Dario Nalagan)	72	Systemic Amyloidosis	159
Arthritis, Treatment of the Common Forms of: Panel Discussion (Robert M. Stecher)	1037	Disseminated Lupus Erythematosus	267
Asphyxia in the Newborn—Pathologic Considerations (Benjamin H. Landing)	1047	Adenocarcinoma of the Stomach	384
Atrial Fibrillation, Central Nervous System Influence in the Genesis of (Jack Marks)	1054	Subacute Bacterial Endocarditis	596
Back, Low, Pain (Ben R. Wiltberger)	35	Tetralogy of Fallot	729
Bleeding, Gastrointestinal, of Unknown Origin (Jack E. Tetrick)	1184	Nephrosclerosis	841
Calcium Glycerophosphate, Comparative Evaluation of, as a Dietary Calcium Supplement (Albert G. Worton; Theodore E. Byers, and James M. Gillingham)	1040	Acoustic Neurinoma	947
Calcium Supplement, Dietary, Comparative Evaluation of Calcium Glycerophosphate as a (Albert G. Worton; Theodore E. Byers, and James M. Gillingham)	1040	Periarteritis Nodosa	1056
Cancer, Pelvic, Delay Committee, Franklin County, Report — 42, 153, 254, 376, 500, 604, 735, 837, 956, 1060, 1190, ...	1300	Arteriosclerotic Heart Disease and Diabetes Mellitus	1191
Carcinoma of the Cervix, Some Urological Aspects of: A Review of Recent Literature (John C. Buckingham and Jack N. Taylor)	255	Postoperative Stenosis of Common Bile Duct	1311
		Conjunctivitis, Management of (William H. Havener)	40
		Dermabrasion, Planing Treatment of the Skin, for Scars (Raymond S. Rosedale)	491
		Diabetes Mellitus, Diagnostic Procedures in,—A Clinical Review of Five Hundred and Forty-Five Cases (Frank W. Anzinger)	1181
		Diabetes, Rational Treatment of (Henry J. John)	1173
		Diagnostic Centers, Children's Cardiac (Robert A. Lyon)	1050
		Dizzy Patient, The (Charles E. Kinney)	365
		Dromedary Symptom Complex, The: The Evolution of an Error (Byron Stinson)	50
		Drugs, Mood-Changing, New (Chauncey D. Leake)	369

Drugs, The Use of, in Otolaryngology (F. W. Davison)	141	Mental Illness, Environment and, : A Study of Urban-Rural Differences in Social Organization (Robert M. Frumkin and Miriam Z. Frumkin)	32
Drug User, Adolescent, Toward Understanding the (William E. Todd and Ross M. Bleak)	821	Meprobamate, Intoxication with, Near-Fatal Case of, Treated with Electro-Stimulation and Levarterenol (Adam G. Allen and A. V. Black)	1303
Ear, Middle, Effusion, Allergies as Causes of (Robert E. Boswell)	374	Meprobamate, Overdosage with—Presentation of Case (E. Crede Hiestand)	1306
Electroshock Treatment, The Use of Succinylcholine Chloride in (Robert W. Buckley and Warren L. Richards)	481	Meprobamate Toxicity—Report of a Case (Myrtle Collins-Dineen)	1304
Embolism, Amniotic Fluid, Presumed, with Recovery (Jack A. Pritchard and Robert J. Dugan)	379	Mood-Changing Drugs, New (Chauncey D. Leake)	369
Environment and Mental Illness: A Study of Rural Differences in Social Organization (Robert M. Frumkin and Miriam Z. Frumkin)	32	Neo-Silvol® and Terramycin®, A Comparative Study of, as Prophylactic Treatments in the Eyes of the Newborn (Kenneth J. Chapman, Jr.)	591
Eyes of the Newborn, Prophylactic Treatments in the, A Comparative Study of Neo-Silvol® and Terramycin® as (Kenneth J. Chapman, Jr.)	591	Nervous System, Diseases of the—A Pediatric Review (Edward C. Matthews)	43
Fallopian Tube, Plastic Operations of the (Samuel L. Vinci)	485	Newborn, the, Asphyxia in—Pathologic Considerations (Benjamin H. Landing)	1047
Fallopian Tube, Primary Carcinoma of the (Reid P. Joyce)	944	Newborn, the, Eyes of, Prophylactic Treatments in the, A Comparative Study of Neo-Silvol® and Terramycin® as (Kenneth J. Chapman, Jr.)	591
Fibrillation, Atrial, Central Nervous System Influence in the Genesis of (Jack Marks)	1054	Newborn, the, Hyaline Membrane Disease of—A Pediatric Review (Louise W. Rauh)	493
Formula, Proprietary Milk, Evaluation of a, on the Growth and Development of Infants (Harry D. Pasachoff; Michael G. Mulinos; David Steinberg, and Albert Sherwyn)	1308	Newborn, the, Rupture of the Stomach in, The Etiology of (Harvey H. Musser)	838
Fractures, Recent, of the Nose, Care and Treatment of (J. Gordon Himmel)	375	Newborn, the, Some Respiratory Problems of—A Pediatric Review (Edward C. Matthews)	382
Freudianism, Rise and Decline of, Part I, and Part II (Max Serog)	388, 501	Nose, Fractures of the, Care and Treatment of (J. Gordon Himmel)	375
Gastrointestinal Bleeding of Unknown Origin (Jack E. Tetrick)	1184	Obstruction of the Respiratory Passages (John Storer)	589
Gonorrhea, The Treatment of, with Oxytetracycline Intramuscular (Ollie M. Goodloe and Louis J. Roth)	34	Omphalocele in General Practice (Presentation of a Case) (Perry R. Longaker and Glenn J. Greer)	938
Hearing, Loss of: The Patient and His Problem (Richard H. Wehr and Marshall A. Becker)	709	Operations, Plastic, of the Fallopian Tube (Samuel L. Vinci)	485
Hemorrhoids, Control of, by the Patient (J. G. Rosenbaum)	490	Ophthalmoscope, the, Introduction to Use of (William H. Havener)	1301
Infant Weighing (Charles T. Wehby)	1049	Otolaryngology, The Use of Drugs in (F. W. Davison)	141
Infants, Growth and Development of, Evaluation of a Proprietary Milk Formula on the (Harry D. Pasachoff; Michael G. Mulinos; David Steinberg, and Albert Sherwyn)	1308	Oxytetracycline-Hydrocortisone Ointment, Responses of Bacterial Infections of the Skin to (Ashton L. Welsh and Mitchell Ede)	833
Infarction, Myocardial, Acute—An Analysis of 234 Cases (M. P. Sambhi and Henry A. Zimmerman)	718	Oxytetracycline Intramuscular, The Treatment of Gonorrhea with (Ollie M. Goodloe and Louis J. Roth)	34
Infections, Bacterial, How Well Do We Treat? (Robert C. Kirk)	154	Pantho-F® Ointment, Observations on (Ashton L. Welsh and Mitchell Ede)	1052
Infections, Bacterial, of the Skin, Responses of to Oxytetracycline-Hydrocortisone Ointment. (Ashton L. Welsh and Mitchell Ede)	833	Paraldehyde, Overdose, Accidental Severe, of, with Recovery: Case Report (Albert J. Gilbert)	826
Intoxication with Meprobamate, Near-Fatal Case of, Treated with Electro-Stimulation and Levarterenol (Adam G. Allen and A. V. Black)	1303	Pathologists, the Ohio Society of, Proceedings of Fall Meeting Held at the Department of Pathology, University of Cincinnati College of Medicine, September 17, 1955	497
Liver, Massive Rupture of the, Liver Function Studies in a Case of (Jerome H. Meyer; Raymond M. Kahn, and Malcolm Block)	933	Pathologists, the Ohio Society of—(See Clinicopathological Conference)	
Lobe, Frontal, Procaine Injections, The Use of in the Treatment of Mental Disorder (James M. Whitworth; Laurence M. Weinberger; Mendel Zimblar, and Albert F. Paolino)	727	Patient, the, To Be Anesthetized, The Psychological Approach to (Richard C. Miller)	261
Lung, Carcinoma of the, The Present Status of (Earle B. Kay and Frederick S. Cross)	933	Patients, Psychiatric, The Achievement of Ambulation in (Janice A. Mendelson)	25
Maternal Health in Ohio—Maternal Mortality Studies on: Hemorrhage	951	Pediatric Reviews:	
Infections	1045	Diseases of the Nervous System (Edward C. Matthews)	43
Toxemia	1188	Indications for Urologic Investigation in Infancy and Childhood (Louis Schwab)	156
Anesthesia	1298	The Diagnosis of Pheochromocytoma in Children (Louis Schwab)	259
Medical College, Starling, Meetings of the Faculty of, in 1858 (Jonathan Forman) 734, 953, and	1061	Some Respiratory Problems of the Newborn (Edward C. Matthews)	382
Medical Record, Ohio's Enviably, A Chronological Review of, Part II—The Second Seventy-Five Years (Linden F. Edwards), 1196, and	1316	Hyaline Membrane Disease of the Newborn (Louise W. Rauh)	493
Medical Research Society, The Northside, 1908-1910 (Jonathan Forman), 165, and	272	P Factor, Relation to the, Transfusion Hazards: Report of a Case Demonstrating a (George R. Dochat)	940
Membrane, Hyaline, Diseases of the Newborn—A Pediatric Review (Louise W. Rauh)	493	Pheochromocytoma in Children, The Diagnosis of—A Pediatric Review (Louis Schwab)	259
Mental Disorder, the Treatment of, The Use of Frontal Lobe Procaine Injections in (James M. Whitworth; Laurence M. Weinberger; Mendel B. Zimblar, and Albert F. Paolino)	727	Physician, Pioneer,—Dr. Charles Henry Wetmore (Gilbert Dodds)	1062
		Physician, Rural,—Dr. Isaac Connor Swett (Chester P. Swett)	846
		Piromen,® An Appraisal of, as a Dermatological Chemotherapeutic (Ashton L. Welsh and Mitchell Ede)	148
		Pneumonia, Interstitial, in Infancy and Childhood (C. S. Kellogg and D. A. Phillips)	724

Poliomyelitis, Deformity in, Prevention of (Nadene Coyne)	929	Skin, the, Planing Treatment of (Dermabrasion) for Scars (Raymond S. Rosedale)	491
Prednisolone-Aspirin, Combined, Therapy, Evaluation of in the Treatment of Arthritis (M. M. Szucs; Vitalij Holonko; K. M. Forster, and Dario Nalagan)	722	Stenosis, Mitral, Indications for Surgery in (Earle B. Kay and Frederick S. Cross)	714
Prednisolone, Prednisone and, Therapy in Rheumatoid Arthritis: A Gastrointestinal Hazard? (Norman O. Rothermich and Vol K. Philips)	942	Stomach, the, Rupture of, in the Newborn, The Etiology of (Harvey H. Musser)	838
Prednisone and Prednisolone Therapy in Rheumatoid Arthritis: A Gastrointestinal Hazard? (Norman O. Rothermich and Vol K. Philips)	942	Succinylcholine Chloride, The Use of, in Electroshock Treatment (Robert W. Bulkley and Warren L. Richards)	481
Psychiatry, A Growing Force in—Some Reflections on Group Psychotherapy (Irving L. Berger)	827	Swett, Dr. Isaac Connor, Rural Physician (Chester P. Swett)	846
Psychological Approach, The, to the Patient To Be Anesthetized (Richard C. Miller)	261	Symptom Complex, The Dromedary: The Evaluation of an Error (Byron Stinson)	50
Psychotherapy, Group, Some Reflections on—A Growing Force in Psychiatry (Irving L. Berger)	827	Terramycin,® Neo-Silvol® and, A Comparative Study of, as Prophylactic Treatments in the Eyes of the Newborn (Kenneth J. Chapman, Jr.)	591
Red Eye, the, Differential Diagnosis of (William H. Havener)	836	Transfusion Hazards: Report of a Case Demonstrating a Reaction to the P Factor (George R. Dochat)	940
Report, Franklin County Pelvic Cancer Delay Committee 42, 158, 254, 376, 500, 604, 735, 837, 956, 1060, 1190, and	1300	Urological Aspects, Some, of Carcinoma of the Cervix: A Review of Recent Literature (John C. Buckingham and Jack N. Taylor)	255
Respiratory Passages, Obstruction of the (John Storer)	589	Urologic Investigation, Indications for, in Infancy and Childhood—A Pediatric Review (Louis Schwab)	156
Respiratory Problems, Some, of the Newborn—A Pediatric Review (Edward C. Matthews)	382	Uveitis, Diagnostic Problems in (Arthur M. Culler; Torrence A. Makley, James W. Long, and Ted Suie)	593
Rhinitis, Atrophic, Effective Surgical Treatment for (William H. Saunders)	488	Wetmore, Dr. Charles Henry—Pioneer Physician (Gilbert Dodds)	1062
Shoulder, Anterior, The Impacted (Nicholas Misischia)	377		

AUTHORS OF CLINICAL PAPERS AND CASE RECORDS

Allen, Adam G. (Dayton)	1303	Goldman, Leon, (Cincinnati)	601
Amstutz, H. M. (Lancaster)	164	Goodloe, Ollie M. (Columbus)	34
Anzinger, Frank W., Jr. (Springfield)	1181	Greer, Glenn J. (Albion, Pennsylvania)	938
Becker, Marshall A. (Columbus)	709	Havener, William H. (Columbus)	40, 836, 1301
Berger, Irving L. (Cleveland)	827	Hiestand, E. Crede (Old Fort)	1306
Black, A. V. (Centerville)	1303	Himmel, J. Gordon (Cleveland)	375
Blatt, Hermann (Cincinnati)	1293	Holonko, Vitalij (Youngstown)	722
Bleak, Ross M. (Columbus)	821	Holzaepfel, John H. (Columbus) 42, 158, 254, 376, 500, 604, 735, 837, 956, 1060, 1190, 1300	
Block, Malcolm (Dayton)	933	Hunter, Curwood R. (Cincinnati)	264
Boswell, Robert E. (Dayton)	374	John, Henry J. (Cleveland)	1173
Buckingham, John C. (Cleveland)	255	Jolly, Paul N. (Cincinnati)	497
Buckley, Robert W. (Cincinnati)	481	Joyce, Reid P. (Xenia)	944
Byers, Theodore E. (Columbus)	1040	Kahn, Raymond M. (Dayton)	933
Chapman, Kenneth J., Jr. (Columbus)	591	Kay, Earle B. (Cleveland)	249, 714
Coyne, Nadene (Cleveland)	929	Kellogg, C. S. (Swanton)	724
Cross, Frederick S. (Cleveland)	249, 714	Kinney, Charles E. (Cleveland)	365
Culler, Arthur M. (Columbus)	593	Kirk, Robert C. (Columbus)	154
Davison, F. W. (Danville, Pennsylvania)	141	Landing, Benjamin H. (Cincinnati)	1047
Dineen, Myrtle Collins (Kent)	1304	Leake, Chauncey D. (Columbus)	369
Dochat, George R. (Akron)	940	Levine, Benjamin (Cleveland)	937
Dodds, Gilbert (Columbus)	1062	Long, James W. (Columbus)	593
Dugan, Robert J. (Cleveland)	379	Longaker, Perry R. (Conneaut)	938
Ede, Mitchell (Cincinnati)	148, 833, 1052	Lyon, Robert A. (Cincinnati)	1050
Edwards, Linden F. (Columbus)	1196, 1316	Makley, Torrence A. (Columbus)	593
Forman, Jonathan (Columbus)	165, 272, 734, 953, 1061	Marks, Jack (Columbus)	1054
Forster, K. M. (Youngstown)	722	Matthews, Edward C. (Cincinnati)	43, 382
Frumkin, Miriam Z. (Buffalo, New York)	32	Mendelson, Janice A. (Dayton)	25
Frumkin, Robert M. (Buffalo, New York)	32	Meyer, Jerome H. (Dayton)	933
Gilbert, Albert J. (North Canton)	826	Miller, Richard C. (Dayton)	261
Gillingham, James M. (Columbus)	1040		

Misischia, Nicholas (Cleveland)	377	Steinberg, David (New York City, New York)	1308
Mulinos, Michael G. (New York City, New York)	1308	Stinson, Byron (Clarksburg)	50
Musser, Harvey H. (Akron)	838	Storer, John (Cleveland)	589
Nalagan, Dario (Youngstown)	722	Suie, Ted (Columbus)	593
Paolino, Albert F. (Cleveland)	727	Swett, Chester P. (Lancaster)	846
Pasachoff, Harry D. (New York City, New York)	1308	Szucs, M. M. (Youngstown)	722
Philips, Vol K. (Columbus)	942	Taylor, Jack N. (Columbus)	255
Phillips, D. A. (Swanton)	724	Tetirick, Jack E. (Columbus)	1184
Pritchard, Jack A. (Dallas, Texas)	379	Todd, William E. (Columbus)	821
Rauh, Louise W. (Cincinnati)	493	Vinci, Samuel L. (Cleveland)	485
Richards, Warren L. (Cincinnati)	481	Watson, John S. (Columbus)	581
Rosedale, Raymond S. (Canton)	491	Wehby, Charles T. (Cincinnati)	1049
Rosenbaum, J. G. (North Royalton)	490	Wehr, Richard H. (Columbus)	709
Roth, Louis J. (Columbus)	34	Weinberger, Laurence M. (Akron)	727
Rothermich, Norman O. (Columbus)	942	Welsh, Ashton L. (Cincinnati)	148, 833, 1052
Sambhi, M. P. (Cleveland)	718	Whitworth, James M. (Cuyahoga Falls)	727
Saunders, William H. (Columbus)	488	Wiltberger, Ben R. (Columbus)	35
Schwab, Louis (Cincinnati)	156, 259	Worton, Albert G. (Columbus)	1040
Serog, Max (Dayton)	388, 501	Zimble, Mendel B. (Cuyahoga Falls)	727
Sherwyn, Albert (Elmont, Long Island, New York)	1308	Zimmerman, Henry A. (Cleveland)	718
Stecher, Robert M. (Cleveland)	1037		

GENERAL INDEX

Advertisers, Index to—106, 218, 238, 447, 546, 676, 782, 888, 1002, 1114, 1236, ...1370

Advertising, Classified—107, 219, 339, 448, 547, 677, 783, 889, 1003, 1115, 1237, ...1371

Aging—(See Geriatrics)

American Medical Association—

AMA Clinical Session, Report of November 29-December 2 Meeting, Summary of Official Business, Ohioans Who Participated, 70; Better Get A Film Catalog, 84; All Aboard for AMA's Chicago Meeting, 310; AMA Offers Exhibits on Eye and Ear, 433; New AMA Directory Soon Will Be Ready, 518; AMA To Close Printing Plant After 70 Years Operation, 645; Council on Medical Physics Established by AMA, 749; Mechanical Quackery Booklet May Warn Unsuspecting Patients, 751; AMA Annual Session—Ohio Physicians Who Participated, 752; Committee on Rehabilitation Authorized by AMA Board, 756; AMA Again Will Cooperate with "Medical Horizons" Program, 765; AMA Annual Session—Resumé of Actions of House of Delegates, 853; Revised Code of Ethics Proposed, 864; New Radio Series on Home Safety, 885; Big Sale of AMA Pamphlets, 972; Appointments To AMA Staff, 988; Film on Auto Crashes, 988; Medical-Legal Films, 1077; AMA Clinical Session Planned in Seattle, 1078; Two AMA Health Films Available, 1100; Plaque Honors Dr. Peterson, 1100; AMA Sponsors American Surgical Materials Association, 1107; Hearing Reveals AMA Funds Spent Judiciously, ...1214

American Medical Education Foundation—

Medical Education Week To Be Observed, 392; A Boost for Medical Schools—County Chairmen of AMEF Named, 1086; Time To Make Your 1956 Contribution to AMEF, 1214; Still Time for Contribution, ...1339

Annual Meeting—

1956 Annual Meeting, April 10-12, 65; Hotel Reservation Page, 66; Application for Space in Scientific Exhibit, 67; Resumé of the 1956 Annual Meeting, 169; Guest Speakers for 1956 Meeting, 170; Hotel Page, 172; Announcing the Official Program for the 1956 Meeting, 279; Roster of Delegates, 295; Scientific and Educational Exhibitors, 296; Technical Exhibitors, 298; Workshop in Medical Writing, 294; Here Are Results of Election at Annual Meeting, 509; Reports of the 1956 Annual Meeting, 608; Presenting New Officers, 608; Address of the President, 614; Annual Meeting in Review with Photographs, 618; Proceedings of The

House of Delegates, 624; House of Delegates Roll Call, 636; Annual Meeting Attendance—Roster of Members Present, 637; Physicians Who Attended Annual Meeting Represented Many Branches of Practice, 1077; 1957 Annual Meeting Schedule, 1204; First Call for Entries in Scientific Exhibit, 1206; Application Form, 1207; Hotel Page, 1957 Annual Meeting, 1208; Hotel Reservation Page, 1320; Application Form for Space in 1957 Annual Meeting Exhibit, ...1323

Apparatus—(See under Pharmaceuticals and Apparatus)

Associations, Societies and Organizations—

Ohio State Dental Association, 60; Ohioans Become Fellows of American Academy of Obstetrics and Gynecology, 185; Physicians Invited by Cleveland Society of Obstetrics and Gynecology, 204; Jefferson Medical College Alumni Reunion, 219; Ohio State Surgical Association To Meet, 294; Cincinnati Area Women Physicians To Meet with Attorneys, 297; Warnings on Encroachment of Socialism To Be Theme of Association of American Physicians and Surgeons in Columbus, 302; Ohio Is Well Represented at First Medical Executives Institute, 306; Fort Steuben Academy, 320, 405; Kentucky Association Has New Secretary-Editor, 405; Ohio Society of Pathologists Compiles List of Physicians Doing Cytology Work, 408; Ohio State Radiological Society To Hold Convention, 426; West Virginia State Medical Association Meeting, 447; Chest Physicians To Meet in Germany, 513; Ohio State Golfers' Association To Meet in Dayton, 514; Ohio Valley Proctologic Society Holds Meeting in Florida, 527; World Medical Association Assembly Scheduled in Havana, 611; Fort Steuben Academy, 654; Policy Statement Explains Who Is Considered Registered Technician by American College of Radiology, 743; American College of Physicians Announces PG Courses, 748; Akron Surgical Society Acts on Unethical Practices, 749; Course Offered by American College of Gastroenterology, 756; American College of Radiology Issuing New Publication, 762; Fort Steuben Academy, 768; American College of Surgeons Program Planned, 868; Ten Ohioans Become Fellows of American College of Chest Physicians, 885; Ohioans Scheduled on Program of Michigan Meeting, 885; Friends of the Land 15th Annual Institute, 888; American Fracture Association, 966; Ohioans Voted into American College of Physicians, 982; "International Voice" of Medicine Offers Challenge, 987; American College of Gastroenterology Course, 1069; American Public Health Association, 1077; Aero Medical Association, 1200; Phi Delta Epsilon Sponsors Program in Cleveland, 1230; Ob

and Gyn Board Schedules Exams, 1236; Cincinnati Will Be Scene of National Health Council Forum, 1339; Ft. Steuben Programs, 1368; Cincinnati Area Physicians, ...	1370	Seal Campaign, 278; Ohio's Program for Crippled Children—Activities Described by Medical Director, 605; Ohioan Is in Key Post for National Crippled Children Program, 970; Ohio Services for Crippled Children—Modifications in Medical Policy, ...	981
Attorney General, Legal Opinions— Rules Health Commissioner Must Be Physicians Licensed in Ohio, 886; Hospital as Part of a County Home, 886; Compulsory Hospitalization of TB Patient Rests with Board, 982; In Regard to Medical Treatment and Hospitalization of Prisoners, 1092; Opinion as to Inspection of Premises, ...	1368	Deaths— 83, 202, 324, 430, 528, 650, 764, 874, 992, 1108, 1222, ...	1348
Audit, Annual of OSMA Books	420	Special Committee Presents Memorial To Dr. William M. Skipp, ...	876
Blood— Blood Bank Management Course at Cleveland Clinic. 1205		Disability Benefits— New Social Security Amendments Outlined, 968; New OASI Disability Program, ...	1209
Blue Cross; Blue Shield— (See under Prepaid Medical and Hospital Insurance, and Ohio Medical Indemnity)		District Societies— Fall Postgraduate Programs, 962; Northwestern Ohio Medical Association, 963; Ninth District, 963; Eighth District, 964; Sixth District, 964; Northwestern Ohio Medical Association Meeting Planned, 1072; Eighth District Program, 1072; Ninth District Meeting Planned at Ironton, 1073; Sixth District PG Day, 1073; Northwestern Ohio Medical Association, Report of Meeting, 1237; District Meetings—a Report of Three Successful Meetings, ...	1345
Book Reviews— (See Physician's Bookshelf)		Do You Know— 68, 198, 306, 434, 525, 758, 871, 966, 1104, 1200, ...	1355
Bureau of Workmen's Compensation— Print or Type Your Name on All W. C. Forms, 171; Request Workmen's Compensation Increases—Report of OSMA Committee on Industrial Health and Workmen's Compensation Approved by The Council, 746; Court Says Injury in W. C. Law Must Be Result of Sudden Mishap, ...	961	Economic Factors in Practice— Here's a Present for Your Office Gal, 649; Check Before Picking a Collection Agency, 649; Hospital Costs Biggest Share of Medical Dollar, ...	1216
Cancer— Franklin County Pelvic Cancer Delay Committee Report, 42, 158, 254, 376, 500, 604, 735, 837, 956, 1060, 1190, ...	1300	Ethics, Matters of Policy, etc.— Charging Colleagues a Fee for Services, 84; What About Medication for Athletes? 85; When in Doubt, Better Check, 85; Physician, Patient and Malpractice, 316; Contingent Fee Arrangement Unethical, 318; Ethical Cases Considered by Judicial and Professional Relations Committee and Approved by The Council, 416; When Should You Go to a Lawyer? 524; Akron Surgical Society Acts on Unethical Practices, 749; Revised Code of Ethics Proposed, 864; No Alternative but To Meet the Standards, 984; Watch Your Step on Listing in Directories, 984; If Only Some Doctors Could Realize That, 986; Doctor, Patients and Records, 986; Making Records Available to Colleagues, 1104; Things To Tell Patients About Obesity and Diets, ...	1216
Cancer Conference To Be Held in Detroit, 337; Central Cancer Registry Opened in Columbus, 516; Debunks Hoxsey Treatment for Cancer, 522; How To Make Cancer Registry a Success, 760; Connecticut Releases 17-Year Study, 854; Third Annual Cancer Program, Dayton, ...	963	Financial Report, OSMA— (See under Audit)	
Civic and Governmental Affairs— Poll Conducted on Eisenhower's Health and Second Term, 185; Are You Eligible To Vote? 308; See You at the Polls on May 8, 428; New Bricker Proposal Being Considered, 428; 'Tain't Fair, but This Is an Election Year, 429; Congress Pours Financial Aid into Research Programs, 854; Are You Eligible To Vote? 960; The Vote Is the Payoff, 1063; Party Platforms and Medicine, 1080; Suggested Follow-Up on Elections, ...	1340	Fifty-Year Physicians— (See under County Societies, Activities of)	
Civil Defense— Some Recent Articles on Civil Defense, 1069; County Medical Societies Civil Defense Conference Scheduled, 1084; Civil Defense Conference Scheduled in Chicago, 1205; Some Recent Articles on Civil Defense, ...	1205	General Practitioners— Pennsylvania G. P. Meeting, 171; Cincinnati Area GP's Meet, 306; Seminar for General Physicians on Venereal Diseases Planned in Cincinnati, 544; Cincinnati Area GP's, 658; Ohio Academy of General Practice Sixth Annual Assembly, 849; New AAGP Building in Kansas City Dedicated, 1003; Ohio Academy of GP Program on Hypnosis, 1076; General Practitioners—Report of Sixth Annual Session of the Ohio Academy of GP, 1201; Akron Area GP's Schedule Program, 1213; Mead Johnson Award, Contact AAGP Office, ...	1339
Coming Meetings— 219, 338, 406, 1236, ...	1370	Geriatrics— Older Citizens and the Medical Profession, 316; Aid for Aged Medical Program, 856; Center for Aging Research Established at USPHS, ...	1362
Conference on County Medical Society Officers— Conference Scheduled February 12 in Columbus, 63; Report of Conference Held February 12 in Columbus 411		Heart— Life Insurance Medical Research Fund Makes Grants in Ohio, 74; Ohio Heart Association Plans Program, 200; Inter-Hospital Lectures on Heart Scheduled in Toledo, 275; Cincinnati Chapter, American Heart Association, Program, 323; Cards for Coronary Patients Suggested, 428; Heart and Blood Vessels Will Be Discussed at Sandusky, 433; Youngstown Area Heart Association Elects, 508; Ohio State Heart Association Elects Officers, 509; Central Ohio Heart Association Lists Officers, 1078; Central Ohio Heart Association Fall Program, 1205; Project Committee Will Gather Facts on Heart Disease, ...	1350
Council, The— Proceedings of Meetings of December 10 and 11, 52; Photograph of The Council, 56; Committee on Maternal Health Report to The Council, 60; Committee on Public Relations and Economics Report to The Council, 61; Physician-Hospital Relations—Joint Statement of Principles, 181; Proceedings of March 11 Meeting, 400; General Electric Co. Program Reviewed, 413; Ethical Cases Considered by Judicial and Professional Relations Committee and Approved by The Council, 416; OSMA Decision Upheld in the Case of Dr. C. E. Bolinger by AMA Judicial Council, 646; Proceedings of June 2 and 3 Meetings, 736; Economic and Legislative Issues—Report of Committee on Public Relations and Economics, 742; Hospital Accreditation—Report of the Committee on Hospital Relations, 744; Request Workmen's Compensation Increases—Report of the Committee on Industrial Health and Workmen's Compensation, 746; Anesthesia by Nurses in Obstetrics—Report of the Committee on Maternal Health, 747; Standardized Insurance Report Forms for Physicians is Drafted by Committee, 749; Dr. Mayfield Named to The Council for First District, 852; Proceedings of September 14-15 Meetings in Granville, ...	1064	Historian's Notebook— 51, 165, 272, 388, 501, 601, 734, 846, 953, 1061, 1196, ...	1316
County Societies, Activities of— 92, 206, 328, 435, 532, 661, 770, 878, 996, 1112, 1226, ...	1352	Dr. Frederick P. Waite, Formerly of Cleveland, Is Dead, 504; Wanted Information on Dr. Wm. Maclay Aul, 391; Historic Hildreth Home in Marietta To Remain for Present, 51; Books of Historical Interest, (see Physician's Bookshelf).	
Better Get Busy Now on Your Local Exhibits, 316; Local Cooperation Sought in Project To Interest Students in Science, 320; Cincinnati Academy To Celebrate Centennial Next March, 647; Muskingum County Society Program, ...	963	Hospitals— Physician-Hospital Relations—Joint Statement of Basic Principles, 181; Huron Road Hospital To Present Program, 297; New Chief of Ohio Hospital Facilities Office Named, 306; One-Man Hospital Receives Accreditation, 412; Ohio State Gets Grant for	
Crippled Children— (See also under Poliomyelitis) Ohio Society for Crippled Children Announces Easter			

Study on Hospital Services, 418; Hospital Accreditation—Joint Commission Issues New Edition of Standards, 520; Hospital Construction Drops, 546; Costs One Thing—Payments Another, 648; Hospital Accreditation—Report of OSMA Committee on Hospital Relations Approved by The Council, 745; Ford Foundation Grants to Hospitals in Ohio Exceed \$11 Million, 862; Hospital Accreditation—Special AMA Committee, (Stover) Report Accepted, 870; Legal Aspects of Work of Tissue Committee, 872; New Regulations on Licensure of Maternity Hospitals Adopted, 877; Nonprofit Hospital Not Immune from Liability, Court Holds, 957; Physicians on Hospital Boards, 974; Reply to Stover Report, 1082; Physicians and Hospitals Alerted on Infections in Nurseries, 1084; Toledo Hospital Gets Grant for Leukemia Research, 1106; Hospitals Not Immune to Inflation Spiral, 1342; Iowa Hospital Dispute To Be Taken To Legislature, 1346; Launch Study To Determine Services Hospitalized Should Get, 1367; Lakewood Participates in Study, _____	1370
House of Delegates— Roster of Delegates and Alternates, 295; House of Delegates Minutes of Meeting, 642; Physicians on Hospital Boards—a Subject in Line with House of Delegates Actions, _____	974
In Memoriam— (See Deaths)	
In Our Opinion— Age Groups Should Be Observed in Giving Polio Shots, 84; Business-Industry-Education Day—Has Your Society a Part in It? 84; Mansfield Physicians Use the P. R. Approach, 84; Better Get a Film Catalog, 84; Charging Colleagues a Fee for Services, 84; Policy on Immunizations and Examinations, 85; What About Medication of Athletes? 85; When in Doubt, Better Check (on Local Ethical Practices), 85; Better Get Busy Now on Your Local Exhibits, 316; Plan to Attend Confab on Medical Writing, 316; Physician, Patient and Malpractice, 316; Older Citizens and the Medical Profession, 316; Contracts Must Take Public into Account, 318; Contingent Fee Arrangement Unethical, 318; No Fuss, No Muss, No Worry—No Patients, 318; See You at the Polls May 8, 428; New Bricker Proposal Being Considered, 428; Card for Coronary Patients Suggested, 428; More Leaders Like Bill Skipp Needed, 428; Salute for a 20-Year Job Well Done, 429; 'Tain't Fair, but This Is an Election Year, 429; Hoover Proposal Gathering Dust, 429; It's Vital To Give the Public the Facts, 524; When Should You Go to a Lawyer? 524; Material on Careers in the Health Field, 524; Keep It on a "Down to Earth" Level, 524; Be Sure of Facts About Applicant, 648; Poor Ethics in Handling V. A. Story, 648; Business Trips and Your Income Tax, 648; Costs One Thing; Payments Another, 648; Here's a Present for Your Office Gal, 649; Check Before Picking a Collection Agency, 649; More Facts, Fewer Rumors Desirable, 649; Newspaper Boys Honor Medical Society P. R. Chairman, 760; How To Make Cancer Registry a Success, 760; We Don't Mind Taking a Bow Occasionally, 760; Ohio and School Health Activities, 760; You Can Get New American Medical Directory Now, 762; General Electric Makes Sound Decision, 762; Union Chief Waves Big Stick at St. Vincent's, 762; Legal Aspects of Work of Tissue Committee, 872; Lots of Loose Talk About Lobbying, 872; More V. A. Beds Than Needed for Service-Connected Cases, 872; Offer to Assist Vocational Counselors, 873; New Name But Same Old Policy, 873; Good Booklet for Those in Industrial Practice, 873; No Alternative But To Meet the Standards, 984; Baier at It Again; Our Advice the Same, 984; Watch Your Step on Listing in Directories, 984; Two Safeguards Against Malpractice, 984; It Takes More Than Dues To Keep the Steam Up, 986; "If Only Some Doctors Could Realize That," 986; Doctor, Patients and Records, 986; School Officials Should Disregard Laszlo Letters, 1102; Wealth Not Necessary To Get Medical Education, 1102; Interested in Smaller Tax Bill? 1102; Better Get This Pamphlet and Put It To Use, 1102; Making Records Available to Colleagues, 1104; Resignation of Porterfield a Real Loss to Ohio, 1214; Hearing Reveals AMA Funds Spent Judiciously, 1214; Time To Make Your 1956 Contribution to AMEF, 1214; Congress Should Get Out of the Polio Vaccine Picture, 1214; Hospital Costs Biggest Share of Medical Dollar, 1216; Things To Tell Patients About Obesity and Diets, 1216; Suggested Follow-Up on Local Elections, 1340; Best Prevention May Be Educational Campaign, 1340; Medical Schools Join "Do-It-Yourself" Trend, 1340; Don't Take Insurance Company at Face Value, 1340; Patients'll Like You Better If You'll Just Explain, 1340; Medicine, To Advance, Needs Atmosphere of Freedom, 1342; Hospitals Not Immune to Inflation Spiral, _____	1342
Industrial Commission— (See under Bureau of Workmen's Compensation)	
Industrial Health and Medicine— (See also Bureau of Workmen's Compensation) Congress on Industrial Health To Be Held in Detroit, 63; General Electric Co. Program for Employees Reviewed, 413; Goodrich Company Will Hold Program for Its Doctors, 645; General Electric Makes Sound Decision, 762; Union Chief Waves Big Stick at St. Vincent's, 762; Ohio Department of Health Sponsors Industrial Nurses Institute, 871; Good Booklet for Those in Industrial Practice, 873; Industrial Medical Association Program in Pittsburgh, 966; Data on Absenteeism Studied, 979; United Mine Workers Fund Report, _____	1093
Insurance— Life Insurance Medical Research Fund Makes Two Grants in Ohio, 74; Pamphlets on Health Insurance Being Sent to Physicians, 658; Three Ohio Grants Awarded by Life Insurance Research Fund, 746; Standardized Insurance Report Form for Use by Physicians Is Drafted by OSMA Committee, Approved by The Council, 749; More Gains in Insurance Coverage, 998; Standard Surgical Nomenclature Manual Introduced, 1330; Don't Take Insurance Companies at Face Value, 1340; Estimate Eight Million Ohioans Protected, _____	1344
The Journal— (See also under Medical Writing) Dr. Forman Attends Watershed Meetings, 106; Correction, 306; Salute for a 20-Year Job Well Done, _____	429
Keeping Up With Medicine— 153, 271, 383, 489, 592, 728, 835, 936, 1055, 1195, _____	1297
Laws and Legislation— (See also under Attorney General) Iowa Court Rules that Hospitals Which Profit from Services of Physicians Are Guilty of Corporate Practice, 78; H. R. 7225—Its Dangers, 80; What's New in Congress, 173; Iowa Hospitals Appeal Recent Decision, 200; Appointments Approved by the Ohio Senate, 218; Contract Must Take Public into Account, 318; Pair Involved in Medical Diploma Mill Convicted, 407; Akron Abortionist Sentenced, 408; Debunks Hoxsey Treatment for Cancer, 522; Legal Aspects of Work of Tissue Committee, 873; A Lot of Loose Talk About Lobbying, 872; Nonprofit Hospital Not Immune from Liability, Court Holds, 957; New Social Security Amendments and Other Medical and Health Bills Passed by The Congress, 968; Two Safeguards Against Malpractice, 984; Doctor, Patients and Records, 986; Court of Appeals Upholds Conviction of Diploma Mill Promoters, 986; What Every Physician Should Know About Contracts, 1113; Propose Legislation To Outlaw Dangerous Chemicals, 1201; Types of Deaths Reportable To Coroner, _____	1364
Legal Medicine— Toledo Doctors Take Part in Medico-Legal Institute, 611	
Licensure— (See under State Medical Board)	
Maternal Health— Committee on Maternal Health Reports to The Council, 60; Anesthesia by Nurses in Obstetrics—Statement of Policy by Maternal Health Committee Approved by The Council, 747; Maternal Health in Ohio, 951, 1045, 1188, _____	1298
Medical Education— Private Medical Schools Included in Grants of Ford Foundation, 63; Residency in Allergy at Ohio State, 69; Large Endowments Announced for Western Reserve, 171; Speech Patterns in Psychologic States To Be Studied at Cincinnati U., 173; Resuscitation Courses at Western Reserve, 180; Medical Education Week, 392; Use of Hypnosis To Be Subject at Bunts Institute, 418; Ohio State Gets Grants for Study on Hospital Relations, 418; Postgraduate Services in Anesthesiology, 507; Ford Foundation Announces Matching Funds for Medical Education, 635; Ob-Gyn. Board Accepting Applications, 654; Two Physicians Receive Ohio State Awards, 756; Obstetrics-Gynecology Board Certifies 17 Ohioans, 768; Doctors Representing 41 Nations Are Entertained in Cincinnati, 782; Aviation Medicine at Ohio State, 1094; Wealth Not Necessary To Get Medical Education, 1102; Two Institutions Awarded Grants for Research Facilities, 1216; Medical Schools Join "Do-It-Yourself Trend," _____	1340
Medical Licensure— (See under State Medical Board)	
Medical Writing— Workshop on Medical Writing Scheduled for Annual Meeting, 294; Plan To Attend Confab on Medical Writing, 316; Psychosomatic Dermatology Emphasized at UC, 509; American Medical Writers' Association To Meet, _____	972
Members, Roster of New— 74, 192, 275, 412, 508, 642, 748, 852, 1106, _____	1236

Mental Hygiene—(See under Ohio Department of Mental Hygiene and Correction)

Military Activities—

AMA Membership Cards for Military Service Members, 185; Higher Rating for Physicians in Army Announced, 302; Medical Officers To Get Pay Hike, 647; New Military Dependent Medical Law, 750; New Medicare Program for Dependents, ...1326

Miscellaneous—

No Fuss, No Muss, No Worry—No Patients, 318; These Ohio Pathologists Offer Cytology Diagnostic Service, 408; More Leaders Like Bill Skipp Needed, 428; Creston Citizens Extend Tribute to Dr. Boor, 447; Colleagues Honor Dr. Schriver, 617; Offer To Assist Vocational Councilors, 873; Baier at It Again Our Advice the Same, 984; Applications for Sears-Roebuck Loans Now Being Received, 1002; Physicians Asked To Be on Lookout for Missing Radium, 1368

Narcotics—

Narcotic Licenses Must Be Renewed by July 1, 635; Tighter Narcotics Penalties Urged by Congressional Committees, 777; Toledo Area Doctors Advised About Lack of Agent in that Area, 970; Illegal Use of Narcotics in Ohio Reported Cut, ...1081

Nursing—

Advisory Council, Enlarged Nursing Board Appointees Named, 185; Practical Nurse Association Plans Series of Refresher Courses, 506; Procedure for Reregistration of Nurses Is Outlined, 527; Be Sure of Facts About Applicant, 648; Anesthesia by Nurses in Obstetrics—Statement of Policy by Maternal Health Committee Approved by The Council, 747; How Registered Nurses Should Renew Licenses by Jan. 1, 1957, 768; Occupational Health Nursing Courses, ...1115

Ohio Department of Health—

New Certificates of Birth and Death Issued by Department, 76; Notifiable Diseases—New Form for Reporting Communicable Diseases, 304; New Chief of Ohio Hospital Facilities Office Named, 306; Physicians Invited To Offer Advice on Small Hospitals' Diet Manual, 320; All Ohio Mothers Will Be Notified of Babies' Birth Registrations, 418; Institute for Health Commissioners Scheduled in Granville, 617; Public Health Meeting Scheduled in Atlantic City, 756; Health Commissioner Positions Available in Ohio, 766; Ohio Department of Health Sponsors Industrial Nurses Institute, 871; New Regulations on Licensure of Maternity Hospitals Adopted, 877; Physicians and Hospitals Alerted on Outbreak of Infections, 1084; 37th Annual Conference of Health Commissioners, ...1212

Ohio Department of Mental Hygiene and Correction—

Appointments to Advisory Council to Division of Mental Hygiene Approved, 218; Mental Hygiene Building Program Set in Motion by Legislature, 278; Ohio Mental Hospitals Will Release Numerous Elderly Patients for Protective Care in Homes, 406; Dr. Leonard P. Ristine Appointed Acting Commissioner, 408; Ohio Mental Hospitals—Announce Continuing Decrease in Number of Patients, 514; Division of Mental Hygiene Announces Appointments, 544; Needed Medical Officer for New Marion Correctional Institution, 645; New Buildings Being Added to Ohio's Mental Institutions, 745; Folder Issued About Clinic for Mentally Retarded, 987; Mental Hygiene—Dr. Porterfield Resigns; Appointments Made, 1199; Resignation of Porterfield a Real Loss to Ohio, ...1214

Ohio Department of Public Welfare—

New Aid for the Aged Medical Program, 856; Ohio Services for Crippled Children—Modifications in Medical Policy, ...981

Ohio General Assembly—(See under Laws and Legislation)

Ohio Medical Indemnity—

Dr. Schriver Honored for Work with Blue Shield, 57; OMI Now Covers More Than Two Million Members, 69; Picture of Two Millionth Member and Others, 69; OMI Better Coverage for Large Medical Bills Announced, 512; OMI Will Make Indemnity Check Payable to Both Subscriber and Physician if Authorized, ...756

Ohio State Medical Association—

Increase in Annual Dues Proposed, 176; Facts and Policies About Annual Dues, 312; Material on Careers in the Health Field, 524; Physicians Available Through OSMA Physician Placement Service, 751; Section Officers—Contact Them About Program Participation, 957; New Administrative Assistant Joins OSMA Staff, 972; It Takes More Than Dues To Keep Up the Steam, 986; Warning to All Members (on Payment of Dues), ...1321

Pathologists—

List of Physicians Doing Cytology Work Compiled by Ohio Society of Pathologists, ...408

Pharmaceuticals, Apparatus and Related Products—

Two Drugs in Short Supply, 57; M & R Laboratories Changes Name to Ross Laboratories, 310; Contraindications in Reserpine Cited in FDA Letter, 1069

Physician's Bookshelf—10, 122, 232, 350, 470, 568, 698,

806, 908, 1014, 1152, ...1266
Books of Historical Interest, 167, 274, 504, ...1319

Poliomyelitis—

Still Will Have Polio Problem, National Foundation States, 68; Age Groups Should Be Observed in Giving Polio Shots, 84; Recap on Polio Program in Ohio, 190; Polio Vaccine—Short Supply Cause of Most of the Problems and Confusion, 393; Polio Vaccine—Single Shot Schedule Recommended with Increase in Priority Age Limit, 505; More Facts, Fewer Rumors Desirable, 649; Somewhat Larger Supply of Polio Vaccine Is Coming into Ohio, 656; Salk Vaccine Still Limited by Supply to Ohio Is on the Increase, 755; Health Department Eases Restrictions Somewhat on Inoculations, 886; Dr. Sabin Tours Soviet Union, 889; Polio—a Progress Report in Ohio, 990; Progress Report Given on Incidence of Polio in Ohio, 1107; Congress Should Get out of the Polio Vaccine Picture, ...1214

Postgraduate Activities—(For Graduate Courses See under Medical Education)

Ohio Conference on Human Nutrition Scheduled at OSU, 217; Inter-Hospital Lectures on Heart Scheduled in Toledo, 275; Huron Road Hospital To Present Program, 297; Northern Tri-State Medical Association Assembly (Adv.), 321; Cincinnati Chapter, American Heart Association, To Present Program, 323; Cincinnati Physician Gives Series of Lectures, 337; Cincinnati To Speak at Proctologist Meeting, 392; Ohio State Radiological Society To Hold Convention and Program, 426; Heart and Blood Vessels Will Be Subject at Sandusky, 433; Seminar for General Physicians on Venereal Diseases, 544; Ohio Academy of General Practice Sixth Annual Assembly, 849; Fall Postgraduate Courses Listed, 962; Ohio Academy of General Practice, 962; Muskingum County Program, 963; Cancer Symposium, 963; Northwestern Ohio Medical Association, 963; Ninth District, 963; Eighth District, 964; Sixth District, 964; Postgraduate Courses, 1072; Northwestern Ohio Medical Association, 1072; Eighth District Meeting, 1072; Ironton To Be Scene of Ninth District Meeting, 1073; Sixth District Postgraduate Day, 1073; Rheumatic Diseases To Be Subject at Cleveland Clinic, 1074; St. Luke's Hospital To Present Program, 1076; Ohio Academy of General Practice, 1076; EENT Conference Scheduled at Ohio State, 1077; Endocrines and Nutrition To Be Discussed at Ann Arbor, ...1100

Prepaid Medical and Hospital Insurance—(See Ohio Medical Indemnity and under Insurance)

Public Health, State and Local—(See under Ohio Department of Health)

Public Relations—

Committee on Public Relations and Economics Report, 61; Business - Industry - Education Day—Has Your Society a Part in It? 84; Mansfield Physicians Use the P. R. Approach, 84; It's Vital To Give the Public the Facts, 524; Keep It on a "Down To Earth" Level, 524; You and Your Public—Pointers for Medical Personnel, 526; Here's a Present for Your Office Gal, 649; Issues Considered by Committee on Public Relations and Economics, 742; Newspaper Boys Honor Medical Society P. R. Chairman, 760; We Don't Mind Taking a Bow, 760; Medical Society Leaders Invited to AMA PR Institute, 849; You and Your Public—Report of Chicago Meeting, 1094; Better Get This Pamphlet "To All My Patients" and Put It To Use, 1102; Patients'll Like You Better If You'll Just Explain, ...1340

Rehabilitation—

Rehabilitation Programs in Need of More Trained Personnel, 392; Committee on Rehabilitation Authorized by AMA Board, 756; Erection of Rehabilitation Center at OSU, ...1322

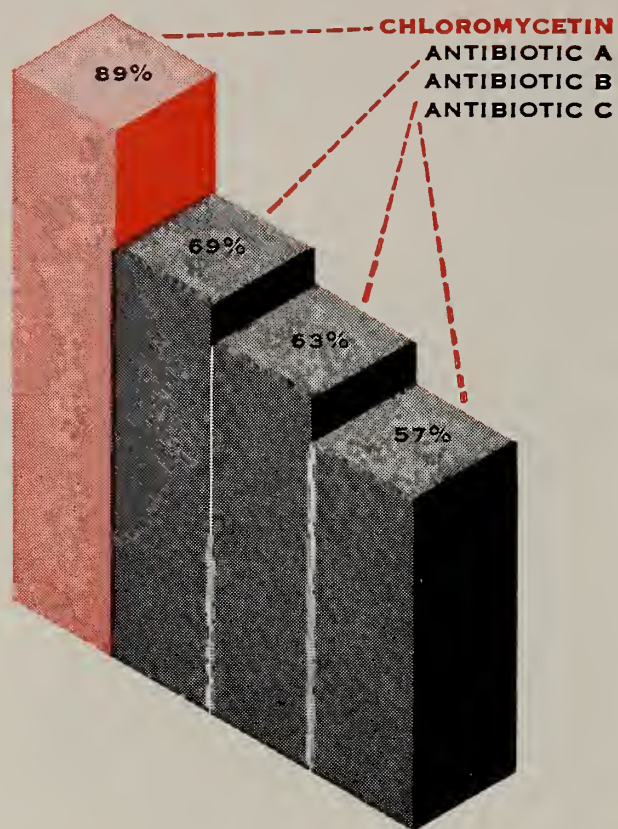
Rural Health—

Senior Medical Students at Two Schools Hear Talks on Practice, 643; Rural Medical Scholarship Awarded, ...988

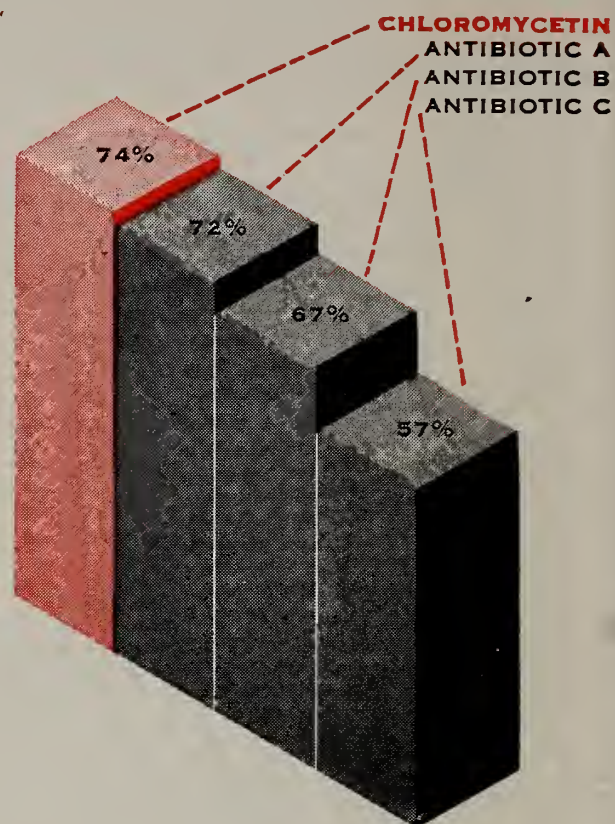
Safety—

Profession Represented in Move To Curb Toll on Highways, 994; Best Prevention May Be Educational Campaign, 1340; Lack of Caution Blamed, ...1354

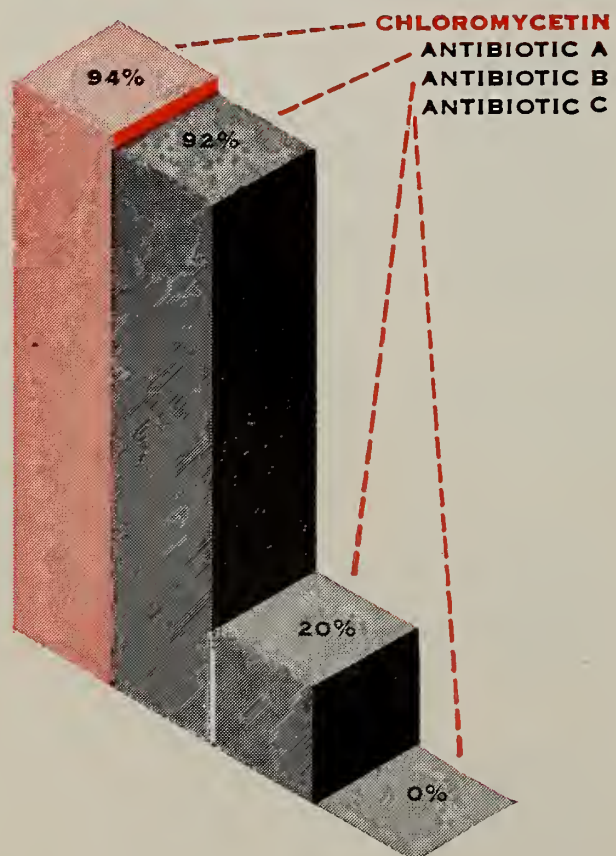
School Health—	
Policy on Immunizations and Examinations, 85; Two Ohioans Head Joint Committee on Health Problems in Education, 755; Conference on Physicians and Schools at Lake Hope, 757; Ohio and School Health Activities, 760; Competitive Athletics in Schools Is Subject of Pediatrics Report, 870; School Officials Should Disregard Laszlo Letters, ...	1102
Scientific Exhibits— (See under Annual Meeting)	
Socialization of Medicine—	
Federal Medical-Health Spending Passes \$2¼ Billion Mark, 82; Warnings on Encroachment of Socialism To Be Theme of Association of American Physicians and Surgeons, 302; New Bricker Proposal Being Considered, 428; New Name But Same Old Policy (AFL-CIO), 873; Federal Health Spending, 1322; Medicine, To Advance, Needs Atmosphere of Freedom, ...	1342
Social Security—	
H. R. 7225—Its Dangers, 80; Trends in Social Security, 180; OASI and Physicians, 186; Disability Freeze Provisions of Social Security, and Set-Up in Ohio, 188; New Disability Benefits Under Social Security Amendments, 968; New OASI Disability Program, ...	1209
State Medical Board—	
Licensed Through Endorsement, 90; December Examinations—Number Who Took Exams and List of Questions, 194; Report of Board for 1955, 337; Pair Involved in Medical Diploma Mill Convicted, 407; Licenses Granted as Result of December Examinations, 422; Licensed Through Endorsement, 424; Correction on Previous Listing of Foreign Medical School, 537; Licensed Through Endorsement, 660; Questions for June Examinations, 866; Licensed Through Endorsement, 1000; Licenses Granted as Result of June Examinations, 1088; Licensed Through Endorsement by State Medical Board, ...	1220
Story Behind the Word— 167, 274, 368, 496, 588, 726, 840, 946, ...	1307
Taxation—	
Business Trips and Your Income Tax Return, 648; Tax Court Rules that Physician on Salary Is Primarily an Employee, 677; New Regulation Allows Income Tax Deductions for PG Refresher Type Courses, 852; Internal Revenue Service Rejects Kintner Case as Precedent, 982; Interested in Smaller Tax Bill? 1102; Tax Roundup for Physicians, ...	1331
Technical Exhibits— (See under Annual Meeting)	
Technicians—	
Policy Statement by American College of Radiology Explains Who Is Considered Registered Technician, 743	
Tuberculosis—	
Compulsory Hospitalization of TB Patients Rests with Board, ...	982
U. S. Government—	
Federal Medical-Health Spending Passes \$2¼ Billion Mark, 82; Federal Health Spending, 1322; New Medicine Program, ...	1326
Veterans Administration—	
VA Sponsors Clinical Conference Series, 314; Severely Disabled Veterans Taking More Training, 527; VA Announces New Open Ward Program for Certain Mental Patients, 537; Commission Urges Change in Veterans' Benefits, 622; Poor Ethics in Handling V. A. Story, 648; More VA Beds Than Needed for Service-Connected Cases, ...	872
Veterans Affairs— (See under Veterans Administration)	
Vital Statistics—	
Ohio Department of Health Revises Certificates of Birth and Death, 76; Another Low in Mortality Rate Seen for 1955, 106; National Study Shows Where Expected Longevity Is Greatest, 335; All Ohio Mothers Will Be Notified of Babies' Birth Registrations, 418; Ohio Physicians Asked To Help in Medical Statistical Project, 607; Men Show Preference for Marriage, 1069; Change in the Mortality Pattern, 1097; Increased Span of Life Means Fewer Orphans, ...	1210
Washington Roundup— 766, 1096, 1218, ...	1344
What To Write For— 660, ...	1342
Woman's Auxiliary— 98, 210, 332, 441, 538, 668, 779, 880, 1232, ...	1358
Woman's Auxiliary Annual Meeting Program in Cleveland, 300; Huron County Auxiliary Cited, 888; Cleveland Chrysanthemum Ball Planned, ...	1094
Workmen's Compensation— (See under Bureau of Workmen's Compensation)	



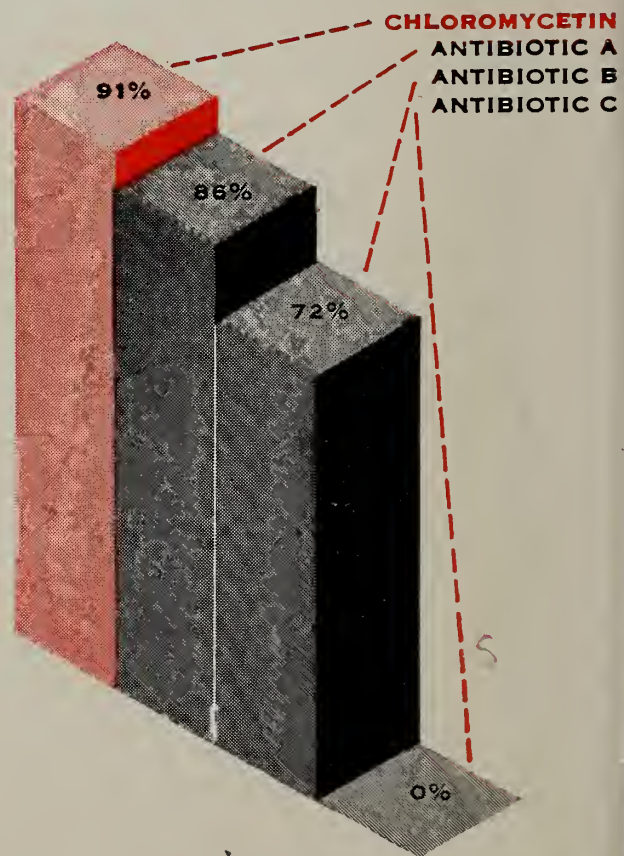
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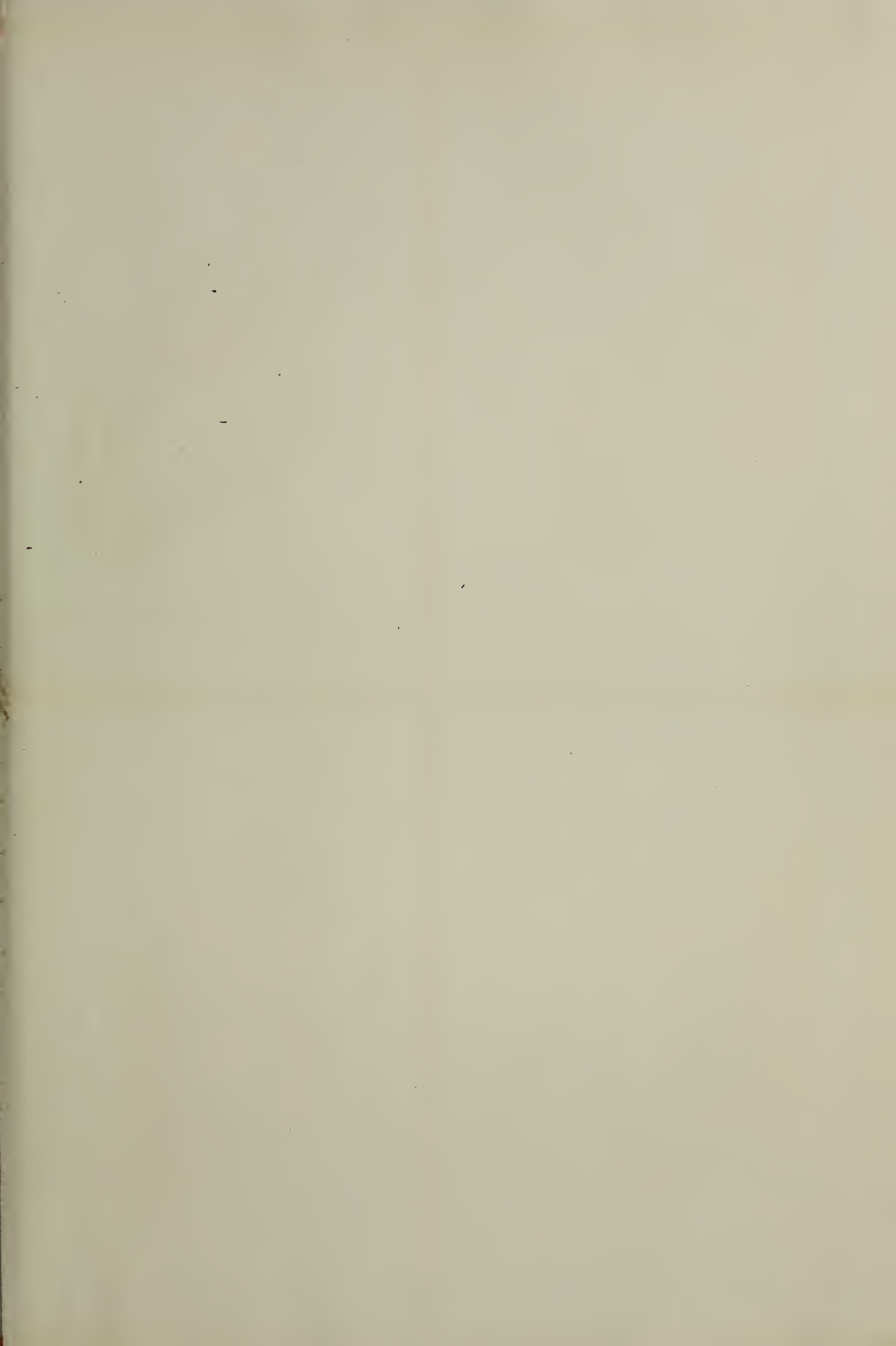
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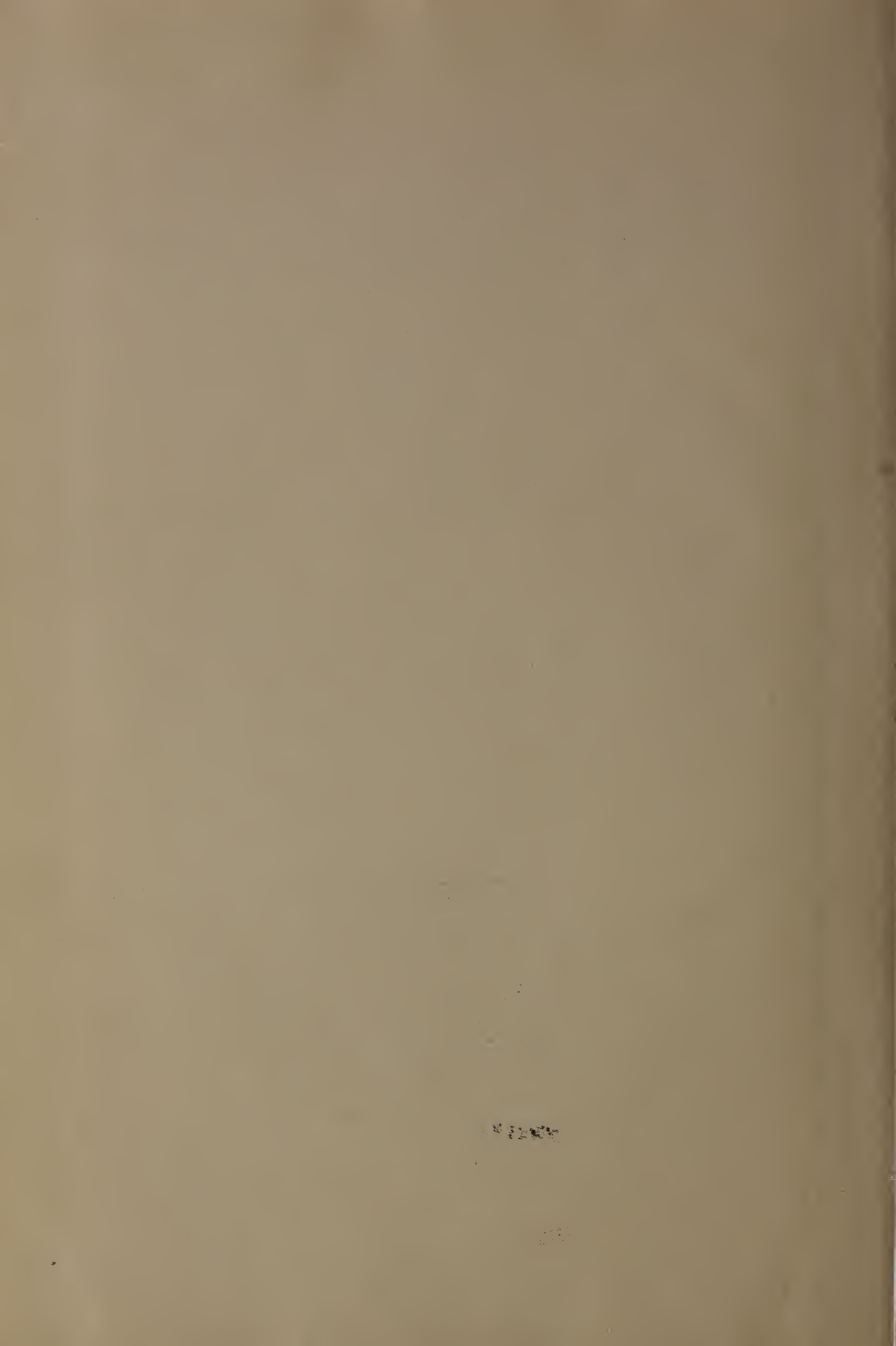


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